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HISTORY

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PRÉVENTION ET TRAITEMENT

POLICY

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LES

Canadiennes

ET L'USAGE D'ALCOOL, DE TABAC ET UTRES DROGUES

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Women's
USE OF ALCOHOL, TOBACCO AND OTHER DRUGS IN CANADA

LES Canadiennes
ET L'USAGE D'ALCOOL, DE TABAC ET D'AUTRES DROGUES

Edited by Manuella Adrian, Colleen Lundy and Marc Eliany

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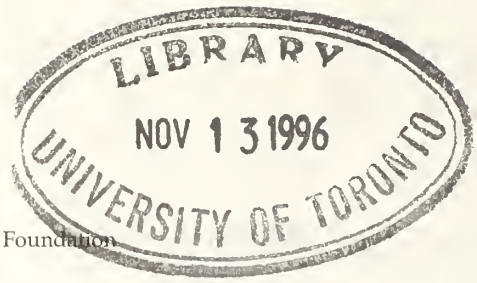

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Preface

Women's Use of Alcohol, Tobacco and Other Drugs in Canada addresses a broad range of issues that affect women and substance abuse in Canada, including treatment and social policy responses. This book takes a feminist perspective on women and substance use, based on pragmatic considerations of the realities of women's everyday experiences.

The initial force behind this project was Marc Eliany, of the Department of Health and Welfare Canada (now Health Canada), who, in the Spring of 1990, called a meeting in Ottawa of female Canadian researchers in the addictions field. This meeting was designed to identify issues in the addictions field that pertained to Canadian women. It would serve as a prelude to a review of the literature and an analysis of the data obtained from the National Alcohol and Other Drugs Survey (NADS), both of which could shed some light on issues of particular concern to women at this time. The NADS was the first national Canadian survey that specifically addressed a broad range of concerns in the addictions field, including the nature and extent of the use of alcohol, tobacco and other drugs, the resulting personal, family and community problems, as well as interventions used to deal with these problems. Health and Welfare Canada provided seed money to assist in the project.

The first section of this book places women's substance use within a social and historical context that includes the medicalization of women's life experiences and women's participation in the temperance movement. The next section explores the relationship between substance use and women's life situations, from youth to old age, including the course of their experience in the paid labor force (while employed or unemployed) or in unpaid work in the home. The nature and extent of substance use by indigenous women and the influence of culture on women's use are also studied. The third section addresses substance-abuse issues of particular concern to women, including multiple drug use, the use of licit drugs (both prescription drugs and over-the-counter [OTC] drugs), alcohol-related victimization, and patterns and predictors of alcohol use and abuse in women. The final section examines prevention, social policy strategies and treatment for women. The authors take account of the fact that most programs have been developed for men and have not provided for women's needs.

A collaborative work such as this inevitably entails the contributions of numerous people. The editors must first thank the chapter authors for their contributions. The views expressed in this publication are those of the authors and do not necessarily reflect those of the organizations with which they are associated. In addition to the authors, the editors would like to thank Denise Lachance, who offered administrative assistance early in the project; Florence Kellner, who has reviewed many of the chapters in this book; Iris Taylor and Joan Vance for initial editing; Karen Shenfeld for copy editing; Joan Moreau and Anca Ialomiteanu, who provided bibliographic and text editing; Anton Helman, who prepared a number of the chapter summaries; Anca Ialomiteanu, for her translation assistance; Louise Nadeau and Lise Saint-Jean, who reviewed the French summaries; Liz Thompson, for word processing the final draft; and Jennifer Griffiths and Minghao Her, for their assistance. We would also like to thank the Editorial Services, Creative Services and Marketing staff of the Addiction Research Foundation for production and publishing assistance. Finally, we must thank Robin Room and Karen Goldenberg of the Addiction Research Foundation for their support of this effort to reveal an important area of concern for women.

Manuella Adrian, Colleen Lundy and Marc Eliany

The Need for a Woman-Centred Approach to Substance Abuse Issues[1]

Manuella Adrian, Florence Kellner[2]

Women make up the majority (50.5 per cent) of Canada's population of 29 million. It was not until recently, however, that women's health concerns were studied by researchers, other than as an extension of studies on men.

This collection reports the results of work undertaken as part of the first comprehensive study of women and substance abuse in Canada. This work was carried out by 32 researchers – most of whom were women – including physicians, sociologists, psychologists, historians, social workers and specialists in a number of other areas.

Using a feminist perspective, we examined a range of issues relating to substance abuse among Canadian women. These issues included: the historical and social forces affecting women's substance use; substance use and abuse through the woman's life cycle, from youth through the working years – whether paid or not – to old age; the experience of special populations, including ethnic minorities and native people; aspects of substance use of particular relevance to women, such as licit and prescription drug use, polydrug use and victimization; treatment of substance abuse among women; and policy issues. This introduction provides a brief summary of the findings presented in the following chapters and offers suggestions for research and policy development relating to substance use by women.

Results from Canada's first comprehensive National Survey of Alcohol and Other Drug Use (NADS) were compared with trends evident in the scientific literature in order to situate the issues discussed in this volume in the context of substance use and abuse patterns among Canadian women. Examination of historical and other archival material was also particularly important in this regard.

The NADS survey was carried out in 1989 and included information on 11,634 Canadians aged 15 and over, of whom 6,343 were women. Data were collected through anonymous telephone interviews (over 98 per cent of Canadian households have at least one telephone) by Statistics Canada, the national government statistical office. Seventy-nine per cent of those contacted as part of the NADS survey responded. Information was obtained on alcohol and other drug use, reasons for use, circumstances of use, influence of family and friends, consequences of use, response to consequences, as well as attitudes, beliefs and opinions. Response rates for individual questions varied between 90 and 100 per cent. (See Chapter 15 for further details.)

Extent of Drug Use

The findings of the NADS survey of psychoactive substance use among Canadian women are summarized in Table 1.

Table 1

Women's Substance Use, Canada, 1989

Substance	Users (%)	
Alcohol	72	
Tobacco	34	
Illicit Drugs		
Marijuana/hashish	4	
Cocaine/crack	<3	
LSD/acid	2	
Speed/amphetamine	<2	
Heroin	<1	
Over-the-Counter Drugs		
Pain relievers/Aspirin	61	
Allergy medications	11	
Cough/cold remedies	21	
Users of Prescription Drugs	**Users (%)**	**Doctor's Orders (%)**
Codeine/Demerol/morphine	6	76
Sleeping pills	5	90
Tranquillizers	4	98
Antidepressants	2	99
Diet pills/stimulants	1	53

Alcohol Use

In Canada, 72 per cent of women reported drinking at least once in the year preceding the NADS survey. Women tended to drink infrequently: only one-third of female drinkers drank once a week or more. Of those who reported drinking in the previous year, more than one-half drank wine (57 per cent), one-third (37 per cent) drank spirits and one-quarter (24 per cent) drank beer. Women typically had 2.2 drinks per occasion and were likely to have had three to four occasions per year when they drank five or more drinks. Women were most likely to drink when they were in bars (95 per cent) or on social occasions (65 per cent), and it was during these occasions that their alcohol consumption was highest. The leading reason given for drinking was to be sociable (74 per cent). Of those who did not drink, almost half (44 per cent) said they chose not to drink because they did not like the taste, while one-quarter cited health reasons.

Tobacco Use

Of Canadian women, 34 per cent said they were current smokers and 23 per cent said they smoked daily. Consumption averaged 17 cigarettes per smoker per day.

Illicit Drug Use

According to the NADS survey, one in five Canadian women had used marijuana or hashish at least once in their lives, although only four per cent had done so in the past year. Ten per cent of users used the drugs two or more times a week. Marijuana/hashish was usually used at home (89 per cent of users) or at a party (60 per cent), with friends (91 per cent), in order to feel high (71 per cent), to feel relaxed (64 per cent) or to see what it was like (60 per cent).

Other illicit drug use was less frequent. Over the year preceding the survey, less than three per cent used cocaine/crack, about two per cent used LSD or acid, less than two per cent used speed or amphetamines, and less than one per cent (0.6 per cent) used heroin.

Licit Drug Use

Regarding prescription narcotic or psychoactive drug use, over the month preceding the survey, six per cent of women reported using codeine, Demerol or morphine, five per cent used sleeping pills, four per cent used tranquillizers such as Valium, two per cent used antidepressants and one per cent used diet pills or stimulants. Over 90 per cent (and up to 99 per cent in some cases) of tranquillizer, sleeping pill or antidepressant use was on doctor's orders. Only 75 per cent of narcotic use was on doctor's orders, possibly because in Canada codeine is found in a number of over-the-counter drugs, including Tylenol, 222 and some cough remedies, in doses of eight milligrams or less. For some respondents, the category "diet pills" may also have included over-the-counter preparations, which may account for the low proportion (53 per cent) who used these products on doctor's orders.

With regard to over-the-counter drugs available without prescription, 61 per cent of women reported the use of pain relievers such as Aspirin, 11 per cent used allergy medicines and 21 per cent used cough or cold remedies.

Comparison to Men's Substance Use

Canadian women were less likely than Canadian men to consume alcohol or illicit drugs, but they were more likely to smoke or use legal prescription or over-the-counter drugs. While the same overall pattern of alcohol, tobacco and drug use was found in all categories of women, there were variations among certain age and occupational groups.

Age and Work Status

The consumption patterns of younger women and working women tended to converge with patterns of use by men. Compared with other women, those aged 15 to 19 were more likely to use marijuana, diet pills or tobacco – more young women than young men smoke – but were less likely to drink alcohol or use other licit or illicit drugs. Working women were more likely than homemakers or unemployed women to drink, smoke or use marijuana. Homemakers were more likely to consume licit drugs, with consumption highest among less educated women, poorer women, and women who were widowed or divorced. Women aged 65 and older had the lowest alcohol, tobacco and marijuana consumption compared with women in other age groups or to men, and were more likely to be life-

long abstainers. However, older women were also more likely to be prescribed psychoactive drugs, especially if their incomes were lower (Chapters 4, 5, 6, 9 and 11).

Multiple Substance Use

Multiple drug use was relatively common in women. Women who drank were more likely to smoke, and women who smoked were more likely to drink. The amount of alcohol and tobacco consumed was higher among those who both drank and smoked than among other women. Smokers were more likely to binge drink and have multiple alcohol problems. Women who drank or smoked were more likely to use licit and illicit drugs, especially marijuana, than non-drinking or non-smoking women or drinking or smoking men.

Problem Use

While most women's alcohol use is not problematic, heavy use of alcohol and the use of other psychoactive substances merit attention. The medical and scientific literature indicates that women who drink heavily or who use other drugs may be at risk for a host of social and health problems, including legal, family and interpersonal problems, physical and mental disease, and premature death. In the case of alcohol, for example, heavy use (including the amount consumed or frequency of consumption) is clearly associated with the development of health and social problems. Similarly, the misuse of prescription and over-the-counter medications – including use without a prescription, for recreational purposes, or contrary to doctor's orders – can lead to problems resulting from inappropriate or excessive doses or from interactions with other drugs. The use of tobacco poses a substantial risk for cancer and respiratory and heart diseases. Illicit drug use may expose users to contact with criminal elements as they participate in illegal transactions in an unregulated market. Moreover, illicit drugs are of variable quality and may expose the user to the risk of overdose or other adverse drug reactions, owning to the presence of impurities. Women who inject illicit drugs are also at risk for HIV infection.

Factors in Women's Lives That May Account for Current Patterns of Substance Use

A number of factors may account for some patterns of substance use among women. There is evidence to suggest both that women are much more likely than men to use prescription and over-the-counter drugs to cope with problems and that women's use of these drugs is likely motivated more by the need to cope than by a desire for recreation. Surveys of alcohol and other drug use among Ontario adults have found that considerably more women than men report using sleeping pills and tranquillizers (drugs generally used to deal with problems), while gender differences in the use of stimulants (generally used to achieve euphoria) have been minimal. The surveys also found that the number of women reporting sleeping pill or tranquillizer use was three to 10 times higher than the number reporting stimulant use, depending on the year (Adlaf, Ivis & Smart, 1994).

Young women are particularly prone to feelings of lack of self-worth and to a heightened awareness of their physical appearance. They may turn to substance use to cope with feelings of inadequacy or to control weight gain. There is also some indication that alcohol and drug use by young women may be particularly influenced by the substance use of their male partners (Chapter 4).

Working women may use psychoactive substances as a coping mechanism to deal with work-related stress, critical events, unmet job expectations or the social aspects of their jobs. Those who use alcohol within the job context may tend to "drink like the men" and, therefore, use alcohol at higher levels (Chapter 5).

Overall, higher substance use was reported by women with higher stress levels, lower levels of family helpfulness and poorer health (Chapter 11). Substance use may be linked to the physical exhaustion and perceived lack of time that result from the multiplicity of female roles for the working mother, who must cope with job and family responsibilities including child care (Chapter 5). The higher use of licit psychoactive drugs by women with fewer financial resources may be the result of a combination of greater stress, greater acceptance of prescription drugs for women, physicians' health care practices and the fact that these drugs are usually paid for by the health care system (Chapters 6 and 9).

Ethnic Patterns

Canada's population is multiethnic, multiracial, multilingual and multicultural. It includes aboriginal inhabitants whose history in North America goes back some 20,000 years. Native people now form three per cent of Canada's population and are its most economically deprived group. French settlers began arriving in the seventeenth century, and their descendants presently constitute about 25 per cent of the population, living primarily in the province of Quebec. English settlers started arriving after the British conquest of 1760, and people of British descent now form about one-third of the population. Current immigration encompasses people from all parts of the world, with 54 per cent of the population having at least one parent whose ethnic origin is neither English nor French (Statistics Canada, 1994).

The NADS survey data indicated that each ethnocultural group had its own specific substance-abuse patterns, which differed from those of other groups, from those typical of their country of origin and from the Canadian average. For example, Italian-Canadian and Portuguese-Canadian women were less prone to drink alcohol (despite coming from countries with high levels of alcohol consumption) and when they did drink, they tended to do so mainly at meals. Of those Italian and Portuguese women who used prescription drugs, about half did so without a doctor's prescription, putting themselves at greater risk for adverse drug reactions.

The most recently arrived groups tended to consume less alcohol but more drugs than the Canadian average. However, there were indications that substance use patterns for different groups tended to converge toward the Canadian average over time. Meanwhile, interventions to prevent or decrease substance abuse must address cultural diversity in substance-use patterns by providing culturally appropriate health promotion messages to women from different groups. For example, messages for Italian- and Portuguese-Canadian women should emphasize the need to check with a doctor before sharing one's prescription drugs with sick family members or friends (Chapter 7).

Aboriginal Women

Drinking is most problematic among indigenous or aboriginal populations. While the NADS survey data provide no direct information about aboriginal women, other studies have found that aboriginal women are less likely to have consumed alcohol, either in the past year or in their lives, and are more infrequent drinkers than non-aboriginal women or aboriginal men. Although fewer aboriginal women

consume alcohol, those who drink are more likely to be heavy drinkers, in comparison with non-aboriginal women, and have higher levels of alcohol, cannabis and prescription drug abuse. The rate of admission to alcohol and drug treatment for aboriginal people is 13 times the Canadian average and two to four times the rate for the U.S. Indian population. Aboriginal people have 50 to 100 times the rate of fetal alcohol syndrome as the non-aboriginal population. One study found that 80 per cent of aboriginal women had personally experienced family violence in which alcohol was involved – eight times the national average. Aboriginal women are three times more likely to die a violent death than non-aboriginal women, and seven to 14 times more likely to commit suicide. Both violent death and suicide are markers of alcohol problems and significantly correlated with substance abuse (Chapter 8).

Violence

Alcohol- and drug-related violence is a particularly serious problem for many women. Analysis of the NADS survey data shows that 47 per cent of Canadian women experienced some victimization due to someone else's alcohol use in the year preceding the survey. Women were more likely than men to experience victimization related to family problems, loss of friendship and financial troubles, but they were less likely to experience victimization related to drinking and driving, traffic crashes or assaults. For women, family or marital problems were likely to be combined with financial troubles. Women who drank larger amounts of alcohol on individual occasions ran higher risks than men for victimization in general and for experiencing insults and arguments (Chapter 10).

Treatment

Substance-abuse treatment for women is woefully inadequate – less than five per cent of all substance-abuse treatment programs provide services specifically for women. Most treatment programs are open to men only, although in some cases services are available for both women and men. In general, treatment has been developed by men to treat men's problems. Treatment that is available for women tends to be an offshoot of services for men. Treatment effectiveness has been tested for men but rarely for women. A review of the scientific literature identified fewer than 20 studies of treatment effectiveness among women, despite indications that women and men have different treatment needs. For example, women do better than men in brief interventions and they tend to prefer short-term non-residential treatment. The availability of child care facilities in the treatment context is especially important for women. Aboriginal women, for instance, must often choose between family responsibilities and travelling thousands of kilometres for treatment while leaving their children behind in uncertain child care circumstances (Chapters 12 and 13).

Historical Factors

Historical factors are important in explaining current patterns of substance abuse among Canadian women. Alcohol was introduced to Canada by European settlers and, although there are limited accounts of aboriginal women's drinking, accounts of drinking by Euro-Canadian women prior to the mid-nineteenth century are almost non-existent, according to written history. Women did drink, but this was, for the most part, ignored (Chapter 1).

Women's principal involvement with alcohol was through the temperance movement. The Canadian temperance movement was launched in the early nineteenth century by Anglo-Protestant men. It was not until the late nineteenth century that women formed their own organization, the Women's Christian Temperance Union (WCTU), and went on to dominate the movement. The WCTU, made up of middle-class women, focused attention on the problems arising from working-class men's drinking as it affected their wives and children. Also involved with more general social issues affecting women, such as women's suffrage, labor legislation and the remuneration of domestics, the WCTU took a high moral stance, seeing itself as the embodiment and preserver of "purity and womanhood" (which were equated in its eyes). The recognition of women's problem drinking was incompatible with this view, and alcoholic women were viewed as doubly degenerate. The WCTU's main contribution in the alcohol field was Prohibition. In contrast to developments in the United States, the Canadian prohibition movement failed on a national scale. It did, however, lead to some degree of Prohibition on a provincial or county level between 1855 and the late 1920s – and, in one part of Toronto, up to the 1990s (Chapter 3).

Tobacco originated in the Americas and was first used by aboriginal peoples in traditional, often ceremonial, contexts in which it was smoked or taken as snuff. By the 1500s, it was introduced into Europe as a cure for "women's diseases," among other ailments. However, smoking was predominantly a male activity, while smoking by women was equated with immorality. In Canada, women's organized involvement with tobacco was through the temperance movement, with the WCTU's attempt to bring about tobacco prohibition in the early twentieth century, which was only narrowly defeated. By the 1920s, the first cigarette advertising directed specifically at women began to appear, along with images in silent movies and, later, talking pictures, showing young, sophisticated women smoking. Today, there is almost complete gender parity in smoking.

Patent medicines containing alcohol, laudanum or morphia, or cocaine were introduced into Canada from Europe and the United States in the nineteenth century. A number of these medicines were specifically marketed as cures for "women's diseases" such as fatigue, weakness and gynecologic and obstetric conditions. By the end of the last century, three times as many women as men consumed opiates in this form. Women's high compliance with social norms led to their use of medically prescribed drugs in personal situations where men would have consumed alcohol. The increasing medicalization of everyday life events – such as birth, death, menstruation and menopause – brought women into regular contact with physicians. In the nineteenth century medical view, the root cause of women's problems was seen as internal to the woman, rather than due to external social or economic circumstances, as may have been the case with men's problems. Women's moods, therefore, had to be managed through psychoactive prescription or over-the-counter drugs, such as tranquillizers or painkillers (Chapter 2).

Current Attitudes

Women's nurturing duties (which often cause women to give priority to other people's problems over their own), and the severe social stigma attached to female substance abusers, tend to delay recognition and treatment of women's substance-abuse problems. Physicians are unlikely to diagnose substance abuse in women. Partly, this may be because social norms are antithetical to the existence of substance abuse in women. Substance-abuse problems also present differently in women than in men. For example, the course of the disorder is foreshortened in women, so that severe problems develop

more quickly in women than in men. Thus, there is a tendency for problems to become apparent and to be diagnosed at a more severe stage.

Physicians tend to prescribe psychoactive drugs more readily for women than for men. Drug companies have also spent 30 years promoting to physicians a myriad of new pills to deal with the "difficult" patient, who has traditionally been portrayed in medical advertising as female. As a result, there may be institutional or professional barriers to diagnosing substance abuse that is iatrogenic.

These kinds of experiences with the medical system may contribute to the fact that when women seek treatment for alcohol problems, they are more likely to refer themselves or others to self-help groups such as Alcoholics Anonymous (AA) than to doctors or nurses. This is despite the fact that in Canada, because universal, free medical care is available to all, cost should not act as a disincentive to obtaining medical treatment. Only in the case of treatment for others' drug problems are women more likely to refer people to a physician first and then to self-help groups (Chapter 13).

Women, who have traditionally been socialized to defer to authority figures, have been ill served historically by their compliance with doctors. To be better served, women must overcome this socialization and become assertive in demanding appropriate care. However, a consumer-driven approach to developing appropriate addictions services would require the investment of considerable personal energy by individual women with substance-abuse problems. A more efficient approach would be to ensure structural change that addresses the complex aspects of substance use and abuse among women, and that takes into account social, economic and personal circumstances that affect the extent and nature of problems.

Policy Recommendations

Policy recommendations advanced in this volume focus on the social changes necessary to reduce substance-abuse problems among Canadian women, and to improve their health and the health of Canadians generally. The research agenda should address the need for information based on studies specifically focused on women, rather than on extrapolations from research conducted on men. We recommend the development of research and programs that recognize women's needs and reflect the impact of personal, family, social, economic and cultural circumstances on women's health. Research and program development should encompass prevention and treatment and take into account the context of women's lives and those issues particularly relevant to women. They must consider the special needs of working women, mothers with dependent children, women living in poverty, young women, older women, aboriginal women and women of diverse ethnic and cultural backgrounds. Such an approach is key to improving women's physical and mental health, their well-being and their quality of life (Chapter 14). We intend this collection to be a contribution to this process.

Footnotes

1. An earlier version of this introduction was presented at the 6th International Conference on the Reduction of Drug Related Harm, Florence, Italy, March 26-30, 1995, and the colloquium Santé et qualité de vie des femmes et changements sociaux, CALASS 95 – Congrès annuel de l'Association latine pour l'analyse des systèmes de santé (ALASS), Montreal, Quebec, Canada, May 25-27, 1995.

2. With information from Colleen Lundy, Marc Eliany, Judith Blackwell, Danielle Blais, Virginia Carver, June Chaikelson, Serge Chevalier, Juanne Clarke, Christiane Dini, Lucia Farinon, Roberta Ferrence, Kathryn Graham, Lorraine Greaves, Kathryn Harvey, Suzanne Hill, Eva Janecek, Gillian Leigh, Lynn Lightfoot, Lisa J. MacGregor, Shirley Mills, Pauline Morissette, Louise Nadeau, Antonine Paquin, Linda Pederson, Helen Ross, Kim Scott, Ellen Tabisz, Joyce Thompson, Wilfreda Thurston and Ikuko Webster.

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Perspectives féministes sur l'usage d'alcool, de tabac et d'autres drogues chez les Canadiennes

par : Manuella Adrian et Florence Kellner

Cette étude, menée par 32 chercheurs canadiens, dont la plupart sont des femmes, est la première à se pencher sur la toxicomanie chez les femmes. Elle examine la documentation scientifique ainsi que les données de l'Enquête nationale sur l'alcool et les autres drogues de 1989 (ENAAD). L'échantillon comptait 11 634 répondants âgés de plus de 15 ans, dont 6 343 étaient des femmes. Les données ont été recueillies par Statistique Canada par entrevue téléphonique : 79 p. 100 des personnes interrogées ont répondu aux questions portant sur la consommation de drogues psychotropes, sur les motifs, circonstances, conséquences et réactions aux conséquences de cette consommation, sur l'influence de la famille et des proches, ainsi que sur les attitudes, croyances et opinions sur cette question. Le taux de réponse à chaque question fluctuait entre 90 p. 100 et 100 p. 100.

Le tableau 1 présente le taux de consommation de substances psychotropes par les Canadiennes.

Tableau 1

Taux de consommation de substances psychotropes par les Canadiennes, 1989

Substances	% des consommatrices	
Alcool	72 %	
Tabac	23 %	
Drogues illégales		
Marijuana	4 %	
Cocaïne/crack	3 %	
LSD/acide	2 %	
Speed/amphétamine	< 2 %	
Héroïne	< 1 %	
Drogues légales en vente libre		
Aspirine/analgésiques	61 %	
Allergie/sinutab	11 %	
Remède contre la toux/rhume	21 %	
Drogues légales sur ordonnance		**Avec ordonnance**
Codéine/démérol/morphine	5,8 %	76 %
Somnifères	4,6 %	90 %
Tranquillisants	4,4 %	98 %
Antidépresseurs	2,4 %	99 %
Amaigrissants/stimulants	1,2 %	53 %

Par rapport aux hommes, les Canadiennes sont de moins grandes consommatrices d'alcool et de drogues illégales, mais elles sont de plus grandes consommatrices de drogues légales obtenues avec ou sans ordonnance. De plus, elles ont plus tendance à fumer la cigarette. La consommation des jeunes femmes et des salariées se rapproche de la consommation des hommes. Les jeunes femmes âgées de 15 à 19 ans ont plus tendance à consommer de la marijuana, des médicaments amaigrissants ou du tabac (parmi les jeunes, plus de femmes que d'hommes fument), et elles ont moins tendance à boire de l'alcool ou à consommer des drogues légales ou illégales. Les salariées ont plus tendance que les chômeuses ou les femmes au foyer à consommer de l'alcool, du tabac ou de la marijuana. Les femmes au foyer, quant à elles, ont plus tendance à consommer des drogues légales. De plus, la consommation est plus élevée chez les femmes à faible revenu ou dont la scolarité est moins élevée, les veuves ou les divorcées. Comparativement aux autres femmes et aux hommes, les femmes âgées de 65 ans et plus ont plus tendance à s'être toujours abstenues ou à consommer de faibles quantités d'alcool, de tabac et de marijuana. Cependant, elles sont plus nombreuses, surtout dans la catégorie des femmes à faible revenu, à consommer des médicaments sur ordonnance. L'usage de drogues multiples est un phénomène commun chez les femmes. En effet, les buveuses ont plus tendance à fumer la cigarette et vice versa. La quantité consommée est aussi plus élevée chez ces femmes. Les fumeuses ont plus tendance à boire durant la soirée et à éprouver de nombreux problèmes liés à la consommation d'alcool. Aussi, elles ont plus tendance que les non-buveuses ou les non-fumeuses à consommer des drogues légales ou illégales (surtout de la marijuana).

Parmi les facteurs qui expliqueraient ces tendances, rappelons que les jeunes femmes ont de faibles capacités de valorisation de soi et sont particulièrement préoccupées par leur apparence. Elles sont enclines à consommer des drogues psychotropes à titre de médicaments amaigrissants ou afin d'engourdir le sentiment qu'elles ne sont peut-être pas à la hauteur. De plus, la consommation des jeunes femmes est particulièrement influencée par celle de leur partenaire masculin. Les salariées font usage de ces drogues lors des activités sociales liées à leur travail ou pour combattre le stress professionnel (événements critiques, espoirs d'emploi déçus). Les femmes qui consomment l'alcool dans un contexte professionnel «boivent comme un homme»; celles qui travaillent dans un milieu professionnel féminin (enseignante, infirmière), là où le code tacite est de s'abstenir, boivent à la maison, le soir. Les femmes qui ont le plus tendance à consommer de l'alcool sont celles qui ont une mauvaise santé, qui vivent un stress intense, et dont la famille a moins tendance à s'entraider. L'épuisement physique et le manque de temps découlant des tâches multiples de la «mère au travail» jouent aussi un rôle dans la consommation d'alcool des femmes.

La multiplicité des comportements liés à la consommation d'alcool, de tabac et de drogues découle de la mosaïque ethnique, raciale, linguistique et culturelle du Canada. À chaque groupe son comportement. Ainsi, il est essentiel que les interventions de prévention ou de traitement soient adaptées à chaque groupe : par exemple, on doit rappeler aux Canadiennes d'origine italienne ou portugaise, dont 50 p. 100 prennent des médicaments sur ordonnance sans obtenir d'ordonnance médicale, que ces médicaments sont destinés exclusivement au patient et ne doivent pas être partagés avec le reste de la famille ou les ami(e)s malades. Ces personnes pourraient encourir le risque de réactions néfastes à ces médicaments pris sans surveillance médicale.

La consommation chez les autochtones soulève de graves problèmes. Les femmes autochtones sont de moins grandes consommatrices d'alcool ou le consomment moins souvent que les femmes non-autochtones ou que leurs homonymes masculins. Parmi celles qui boivent, cependant, la quantité consommée est plus élevée que chez les femmes non-autochtones. De plus, les femmes autochtones ont plus tendance à faire un usage abusif d'alcool, de cannabis ou de médicaments sur ordonnance. Le nombre d'inscriptions des autochtones dans les programmes de traitement de la toxi-

comanie est 13 fois supérieur à celui de la moyenne canadienne, et de deux à quatre fois supérieur au nombre d'autochtones américains inscrits en traitement. Le taux de syndrome d'alcoolisme fœtal chez les autochtones est de 50 à 100 fois supérieur à celui des non-autochtones. Parmi les femmes autochtones, 80 p. 100 ont personnellement subi la violence familiale. Ce pourcentage est huit fois supérieur au taux en vigueur parmi les non-autochtones. Comparativement aux femmes non-autochtones, les femmes autochtones courent un risque trois fois plus grand de mourir d'une mort violente. De plus, elles courent un risque de sept à 14 fois plus élevé de se suicider (suicide et mort violente sont des indicateurs de problèmes causés par l'alcool).

Les Canadiennes sont sujettes à subir la violence liée à l'alcool suite à la consommation d'une autre personne : 47 p. 100 des Canadiennes en ont été victimes. Comparativement aux hommes, les femmes ont vécu plus de problèmes familiaux, financiers ou interpersonnels durant l'année précédant l'enquête, mais elles ont moins souvent subi les conséquences de la conduite en état d'ivresse ou de la violence. Cet état ce chose s'explique par le fait qu'elles se trouvent moins souvent sur les lieux de ces incidents. Les femmes doivent souvent affronter de multiples problèmes : disputes ou insultes lorsqu'elles prennent place dans une voiture conduite par une personne en état d'ivresse, ou lorsqu'elles ont des problèmes familiaux ou conjugaux. Dans ce dernier cas, elles ont aussi des problèmes financiers. Les femmes qui consomment de l'alcool ont de plus fortes chances de se disputer ou de se faire insulter.

Le réseau de programmes d'intervention à l'intention des femmes est sous-développé. En effet, moins de cinq pour cent des programmes de traitement sont destinés aux femmes. La plupart des traitements en place ont été mis sur pied pour traiter les hommes, c'est-à-dire les problèmes de toxicomanie tels qu'ils se manifestent chez les hommes. Ces programmes ont ensuite été mis à la disposition des femmes sans que leur efficacité ait été testée sur les femmes, et ce, malgré la tendance qui semble indiquer que les programmes d'intervention ont un meilleur résultat sur les femmes s'ils sont conçus spécialement à leur intention. Par exemple, les femmes profitent plus des interventions brèves et préfèrent les programmes à consultation externe à court terme. L'existence d'un service de garde d'enfants est particulièrement important pour les femmes; surtout pour les femmes autochtones qui doivent parcourir des centaines de kilomètres pour recevoir leur traitement et qui doivent se séparer de leurs enfants et délaisser leurs responsabilités familiales si elles veulent se faire traiter.

De nombreux facteurs expliquent pourquoi les femmes sont si mal desservies en matière de toxicomanie. Le rôle joué par la femme au sein des mouvements de tempérance pour lutter contre l'alcool et le tabac depuis le 19e siècle a marqué celle-ci de l'image de la «pureté féminine» et de «gardienne des valeurs morales». Cette image est incompatible avec celle d'une alcoolique ou d'une toxicomane. Dès le 19e siècle, les développements fulgurants du domaine médical ont accru l'importance du rôle des médecins dans le quotidien où un nombre croissant d'activités comme la naissance, la mort, les menstruations, la croissance des enfants, etc. ont été définies comme étant du domaine médical. Cet état de chose a multiplié les contacts réguliers entre les femmes et les médecins. La médecine a longtemps considéré les femmes comme des êtres déficients et «naturellement maladifs» en raison de leurs différences physiologiques par rapport aux hommes. Leurs organes génitaux et leur psychologie étaient perçus comme pathologiques. Leur rôle «nourricier» au sein de la famille était du masochisme pur. Les problèmes des hommes étaient causés par des difficultés d'ordre matériel externes qui pouvaient être contrôlées en changeant les variables extérieures. Les problèmes des femmes, quant à eux, étaient «internes» et suscités par leurs soi-disant déficiences féminines. Ainsi, seules des interventions médicales pouvaient venir à bout de leur état d'esprit. À cette fin, au 19e siècle en Amérique du Nord, ont été introduites des préparations contenant de l'alcool, du laudanum ou de la morphine et de la cocaïne. Ces préparations étaient supposément des remèdes

aux maladies féminines comme la fatigue, la faiblesse ou les troubles obstétriques ou gynécologiques. Les tranquillisants, somnifères et autres drogues psychotropes légales ont ensuite fait leur apparition au 20e siècle. Ainsi, là où les hommes ont recours à l'alcool, les femmes prennent des produits pharmaceutiques légaux.

Au Canada, la femme alcoolique ou toxicomane a un visage caché. Les contraintes sociales en font une tare de la société, car, en plus de ses problèmes liés à l'alcool et aux drogues, elle a failli à ses devoirs de mère, d'épouse, de femme. Son rôle nourricier, pour le compte duquel les besoins des autres ont préséance sur ses propres besoins, lui font tarder à se faire soigner. Lorsqu'elle daigne enfin se présenter en clinique, son problème lié à l'alcool ou aux autres drogues en est déjà à un stade avancé de son évolution. Ses symptômes sont différents des symptômes des hommes; ses médecins ont donc souvent de la difficulté à les reconnaître. De plus, ils refusent peut-être de voir sa toxicomanie comme étant d'origine iatrogénique. Plutôt que de consulter un médecin, les femmes alcooliques qui veulent recevoir un traitement se tournent d'abord et avant tout vers les programmes d'entraide comme les Alcooliques Anonymes.

Il est fondamental d'élaborer des politiques qui permettent la mise en place de programmes d'intervention qui soient à l'écoute des besoins des femmes, qui reconnaissent l'importance des facteurs personnels, familiaux, sociaux, économiques et culturels au sein desquelles les femmes évoluent et qui influent sur leur santé. L'intervention ne doit pas s'en tenir aux effets psycho-pharmacologique des substances psychotropes, mais prévention et traitement doivent tenir compte du contexte de la vie des femmes et des besoins particuliers des mères, des pauvres, des jeunes, des autochtones et des aînées afin de permettre l'amélioration de la santé physique et mentale ainsi que le bien-être et la qualité de la vie des Canadiennes.

CHAPITRE 1

Histoire de l'usage d'alcool, de tabac et d'autres drogues chez les Canadiennes

par Lorraine Greaves

Il n'existe pratiquement aucun document historique sur l'usage d'alcool, de tabac et d'autres drogues avant le vingtième siècle. Tandis que les peuples autochtones du Canada faisaient usage de tabac pour des raisons médicinales et spirituelles sans pour autant faire usage d'alcool et de drogues psychotropes, de nombreuses Canadiennes d'origine européenne prenaient des remèdes contenant de l'alcool, de la cocaïne et de la morphine à une période où la société les empêchait de consommer de l'alcool ou du tabac.

Les femmes et les hommes d'origine noire ou autochtone ont d'abord été exclus des premiers mouvements antialcooliques. Cependant, des féministes du Canada anglais ont formé des mouvements de tempérance féminins pour lutter contre la consommation d'alcool et de tabac. Le suffrage féminin, la violence familiale et la réforme vestimentaire étaient parmi les thèmes mis de l'avant par «l'Union de tempérance des femmes chrétiennes» (Women's Christian Temperance Union ou WCTU). L'influence des mouvements antialcooliques s'est effritée suite à certains phénomènes sociaux, tels que la vague de patriotisme inspirée par la Seconde Guerre mondiale, l'urbanisation accrue de la population, l'émancipation des femmes et la disparition des politiques européennes protestantes visant à instaurer l'abstinence totale; ces dernières n'ayant jamais été complètement acceptées au Canada français.

Les premières réactions à la consommation d'alcool, de tabac et de drogues des femmes émanaient de points de vue typiques de certaines classes de la société et étaient de nature sexiste et raciste. On jugeait déplacés et immoraux la consommation des femmes, les effets néfastes sur les femmes de la consommation des hommes et le commerce de l'opium, habituellement mené par des hommes asiatiques.

Depuis les années 1930, l'usage de tabac chez les femmes a augmenté, conséquence du marketing agressif auprès de cette population par les fabricants de tabac. Les réactions contemporaines à la consommation des femmes ont aussi un côté sexiste puisqu'elles ferment les yeux sur l'usage d'alcool, de drogues et de tabac chez les femmes qui tentent de composer avec les réalités sociales et le quotidien.

Dans le présent chapitre, l'auteure présente les différences-clés de l'influence du tabac et de l'alcool sur la capacité des femmes à jouer leur rôle social. Enfin, la consommation d'alcool, de tabac et de drogues chez les femmes reflète leur situation sociale et politique, ce qui nous porte à penser que prévention et traitement devraient s'inscrire dans le contexte du rôle de la femme contemporaine dans la société actuelle.

CHAPITRE 2

Contexte historique de la médicalisation selon les sexes : lien avec l'usage d'alcool et d'autres drogues au Canada

par Juanne Clarke

Le présent chapitre examine l'historique de la «médicalisation», laquelle a suscité un usage différent des drogues et de l'alcool chez les hommes et chez les femmes. La médicalisation consiste à définir certaines activités de la vie courante comme étant du domaine médical.

Le vingtième siècle se caractérise par la différentiation de l'usage de drogues et d'alcool selon le sexe. Les hommes ont plus tendance que les femmes à faire un usage abusif ou non d'alcool. Les femmes, quant à elles, ont plus tendance que les hommes à prendre des médicaments sur ordonnance, surtout des drogues psychotropes. Ces différences sont perçues comme concomitantes à la spécialisation des rôles sexuels à mesure que les activités de la vie courante sont définies comme étant du domaine médical (médicalisation). Les professionnels de la santé ont confiné les femmes au rôle associé au sexe faible et les ont traitées en conséquence. Ainsi, les manifestations physiologiques normales comme les règles, la ménopause ou l'accouchement ont été «médicalisées» et sont maintenant traitées de façon médicale. En revanche, la vie et le corps des hommes n'ont pas été médicalisés de la sorte. Par conséquent, les hommes ont continué à présenter des niveaux élevés de consommation et de surconsommation d'alcool.

CHAPITRE 3

Les Canadiennes et les mouvements antialcooliques : un point de vue historique

par Louise Nadeau et Kathryn Harvey

Le présent chapitre pose l'hypothèse selon laquelle la différentiation des pratiques de consommation d'alcool des hommes et des femmes trouve son origine au XIX[e] siècle. Rares sont les historiens qui ont étudié les modèles de consommation d'alcool des Canadiens avant l'apparition des mouvements antialcooliques au Canada, soit autour de 1830. En conséquence, les sources décrivant un système de deux poids deux mesures au sujet de l'ivresse selon les sexes sont presque inexistantes pendant cette période. Lorsque, vers 1840, les mouvements antialcooliques ont mobilisé les masses et sont devenus une croisade populaire, les femmes du Haut-Canada et du Bas-Canada s'y sont jointes. Durant cette période, comme durant la période précédente, certaines sources soulignent une stigmatisation de l'ivresse des femmes mais ces données ne sont pas très probantes. C'est par la «Woman's Christian Temperance Union», fondée en 1874, que le rôle des femmes s'est précisé dans les luttes antialcooliques. Ce regroupement préconisait qu'il était du devoir moral des femmes de protéger leur foyer contre les fléaux de la société. Un des effets pervers de cette nouvelle fonction a été de rendre les femmes responsables de l'ivrognerie des hommes. En outre, les idées concernant la pureté morale des femmes interdisaient toute discussion sur une éventuelle consommation d'alcool chez elles. L'abstinence d'alcool faisait ainsi partie intégrante de la féminité.

CHAPITRE 4

Les jeunes femmes et l'alcool, le tabac et les autres drogues

par Colleen Lundy, Virginia Carver et Linda Pederson

Le présent chapitre se penche sur l'évolution, au cours des dix dernières années, des tendances en matière d'usage d'alcool, de tabac et d'autres drogues chez les femmes âgées de 15 à 19 ans. Nous nous attardons à la situation actuelle à partir des données de l'Enquête nationale sur l'alcool et les autres drogues (ENAAD) de 1989.

L'alcool et le tabac sont toujours les principales drogues consommées par ce groupe. Elles sont aussi la source des problèmes, selon les déclarations des femmes interrogées dans le cadre de l'enquête. Cette analyse a examiné les raisons qui poussent les jeunes femmes à boire ou à s'abstenir. Elle s'est aussi penchée sur les effets néfastes de l'alcool, les tentatives faites par les jeunes femmes pour réduire leur consommation ou y mettre fin, et les expériences consécutives à la consommation d'alcool de leurs proches.

Ces données sont interprétées en fonction des enquêtes nationales antérieures, des études de populations et des résultats d'autres enquêtes internationales.

Le présent chapitre présente également une analyse de la problématique de l'usage de drogues chez les jeunes femmes et associe leur position sociale subordonnée à la manière dont leurs problèmes de drogues se manifestent.

CHAPTER 5

Working Women, Unemployed Women and Housewives: Alcohol, Tobacco, Psychotropic Medication and Drugs in Relation to These Three Employment Statuses

By Pauline Morissette, Antonine Paquin, Serge Chevalier and Danielle Blais

A review of the scientific literature seems to indicate the following: Women who enter the labor market are more likely than others to consume alcohol due to their exposure to new consumption norms, increased financial means (which may increase their ability to purchase alcohol), exposure to changes in social norms, and the desire to manage stress. There is higher than average consumption among younger women, and among separated or divorced women. Women are more likely than men to use psychotropic drugs, and use increases with age. It is not clear if use of alcohol is higher among housewives or among the employed, whose work performance is likely to be affected.

Women, and especially young women, are likely to use tobacco, although tobacco use has been decreasing in a number of groups. Depending on the study, findings indicate high tobacco use among women in management, women who are unemployed or who are blue-collar workers. Tobacco use among women may follow male usage patterns.

Illegal drug use is lower among women than among men, but may be higher among working women, young women or unemployed women, depending on the type of illicit drug. Women are more likely than men to use prescription drugs. There also is evidence among women of higher rates of prescription drug use with concurrent high-level drinking; tobacco use with concurrent high-level drinking; and of marijuana use at certain stages of the menstrual cycle.

Typologies have been developed to classify alcoholic women based on their employment status and to classify women who use psychotropic drugs based on their level of control over drug use or their likelihood of being prescribed drugs. In this chapter, the authors review some of the reasons women consume alcohol or take drugs. The authors examine the issue of stress reduction among working women, typologies that depend upon substance choice, the influence of partners, family, peers or publicity, employment roles, work environment, job satisfaction, interpersonal relations on the job, and responsibility for multiple roles (mother, wife, employee). The effects of substance use on health, work performance and driving ability (drunk driving) are also considered.

Analysis of the National Alcohol and Other Drugs Survey (NADS) data for women aged 20 to 64 reveals a number of findings:

Alcohol – When the three groups classified by working status (working, unemployed and homemakers) were considered together, women who resided in British Columbia reported consuming the highest average number of drinks per week when compared to women in other provinces. As education levels increased, average consumption per week increased. The highest average consumption (2.37 drinks) was found among women earning $40,000 and up per year. The highest proportion of current drinkers was found among single women and the lowest among married women; separated women fell between the two groups in this category. The highest average consumption per week was also found among the group of single women. The highest rate of current drinkers was found among English-speaking women, when compared to groups of French-speaking women or groups of those who spoke other languages. The highest average weekly consumption (2.25 drinks) was also found among the English-speaking women.

Women who reported they were more stressed than average also reported consuming the highest number of alcoholic drinks (2.64 per week). Considering the three work groups combined, four per cent of women aged 45 and older said they consumed alcohol every day during the week preceding the survey. As regards marital status, widows were more likely than the average to report drinking four to six times per week or to report daily drinking.

Licit Drugs – The highest rate of tranquillizer and sleeping pill users was among women aged 55 to 64. As age increased, the percentage of users increased. In the month preceding the survey, there was a higher reported rate of users of tranquillizers and sleeping pills among women with lower levels of education, with yearly incomes less than $10,000, and among previously married women (widowed, divorced or separated). Among women aged 20 to 64, Quebec women were more likely than average to report they used tranquillizers and sleeping pills, as were women who reported poor health status. Current smoking was more likely to be found among younger women than among others, and younger women were the most likely to smoke one to 10, or 11 to 25, cigarettes per day during the week preceding the survey.

A comparison of working women to unemployed women and homemakers found the following:

Alcohol – Unemployed women were slightly more likely than employed women to report they were current users of alcohol and, compared to working women or homemakers, reported consuming a higher than average number of drinks during leisure activities (4.5 vs. roughly two drinks). Employed women differed markedly from unemployed women and homemakers in the average number of drinks they reported consuming per week. Unemployed women were more likely than working women or homemakers to report that they had stopped drinking, while working women were more likely than the other two groups to have decreased their consumption. Regardless of employment status, the most likely reason given for having stopped or reduced drinking was health related. The usual number of drinks reported per activity was roughly the same, regardless of women's employment status, and was low (about 1.5 drinks). Again, regardless of employment status, women reported consuming a higher than average number of drinks (2.5 drinks) when they went to a bar or tavern. Working women and unemployed women were more likely than homemakers to report a variety of alcohol-related problems in their community. Women of all employment statuses were equally likely to be invited to have a drink by their spouses or partners.

Illicit Drugs – Among women aged 20 to 64, a higher percentage of working and unemployed women, compared to homemakers, reported consuming marijuana or hashish at some time in their life.

Licit Drugs – Homemakers were twice as likely as working women to report having used sleeping pills in the month before the survey, and they were more likely to report taking weight-loss pills. In contrast, women in the work world were more likely to report having used codeine, Demerol and morphine.

For women in the paid workforce, which consists of both working women and unemployed women, the following results were found:

Alcohol – The highest proportion of current drinkers was found among women in the paid workforce, aged 20 to 24 and 35 to 44; it was, however, women aged 45 to 54 who consumed the highest number of drinks per week (3.04 drinks). Among working women, managers and professionals were more likely than others to report being current drinkers, but women in blue-collar occupations reported consuming as many drinks per week as managers and professionals (2.69 vs. 2.67 drinks). Working women who had stopped drinking or who had reduced their alcohol consumption were more likely to report having done so by limiting the number of drinks they took rather than by any other means listed in the survey. About three per cent of working women reported drinking four to six times during the week preceding the survey and about two per cent said they drank daily.

Illicit Drugs – About two per cent of women in the paid workforce had consumed cocaine or crack at least once in their life. Women in the paid workforce were more likely to say they consumed marijuana to relax than for other reasons, such as forgetting one's troubles, being sociable, feeling less shy, or seeing what it felt like.

CHAPITRE 6

Les femmes âgées de 65 et plus et leur usage d'alcool et de drogues

par Virginia Carver, Kathryn Graham et Colleen Lundy

La documentation scientifique portant sur l'usage d'alcool et de drogues chez les femmes âgées indique que le taux de consommation d'alcool et de tabac y est plus faible dans ce groupe que dans les autres groupes d'âge. Par ailleurs, l'usage de médicaments psychotropes, sur ordonnance ou en vente libre, est plus élevé. Au cours des dix dernières années, la tendance relative à l'usage d'alcool et de médicaments psychotropes sur ordonnance est demeurée stable ou a accusé une baisse. L'usage du tabac, quant à lui, est à la hausse. Les femmes en bonne santé, scolarisées et qui jouissent d'un bon réseau social ont plus tendance à consommer de l'alcool, alors que l'on observe le contraire en ce qui a trait au tabac. L'usage de médicaments psychotropes sur ordonnance est associé à l'isolement social et à un mode de vie où s'inscrit un niveau de stress élevé. Les femmes âgées ont plus tendance à consommer des drogues multiples alors que peu d'entre elles consomment de grandes quantités d'alcool. De plus, elles présentent peu de problèmes liés à cette consommation. L'Enquête nationale sur l'alcool et les autres drogues (ENAAD) démontre que l'usage d'alcool et de tabac chez les femmes âgées de 65 ans et plus est plus faible que dans les autres groupes d'âge. De plus, l'usage de drogues illégales est rare chez elles. Les femmes âgées de 65 ans et plus ont plutôt tendance à prendre fréquemment des médicaments psychotropes sur ordonnance, par exemple de l'aspirine ou autres analgésiques. L'usage d'alcool et de tabac est plus courant chez les «jeunes aînées» (âgées de 65 à 69 ans), alors que la consommation de médicaments sur ordonnance augmente avec l'âge.

Le taux de consommation est associé à la santé physique et psychologique, à l'éducation et au revenu. L'usage de médicaments psychotropes sur ordonnance est associé à une faible scolarité et une mauvaise santé, un niveau élevé de stress et un manque apparent de soutien émotionnel ou social de la part de la famille ou des amis. Les femmes âgées consomment des drogues multiples. On observe une corrélation entre l'usage d'alcool et le tabagisme, mais pas entre l'usage d'alcool et de médicaments psychotropes; c'est le tabagisme qui est associé à la consommation de tranquillisants et de somnifères. La forte consommation n'est pas courante chez les femmes âgées en raison de l'effet néfaste sur leur santé qu'elles attribuent à un tel usage. Les femmes mariées dont le conjoint boit fréquemment signalent une plus grande consommation d'alcool.

Les mêmes raisons sociales poussent les grandes et les faibles consommatrices à consommer de l'alcool. Cependant, les grandes consommatrices ont plus tendance à boire pour des raisons dites «instrumentales» : pour se «détendre», se «sentir mieux», etc. Il est probable qu'il découlera d'une plus grande consommation d'alcool un plus grand nombre de conséquences néfastes. La hausse de la consommation d'alcool et de tabac chez les femmes âgées peut entraîner l'apparition d'un plus grand nombre de problèmes liés à cette consommation. On pense surtout aux femmes nées durant ou après la Seconde Guerre mondiale et qui auront bientôt 60 ans, celles dont la scolarité est plus élevée et dont le revenu sera plus élevé durant le troisième âge alors qu'elles seront plus souvent exposées à l'alcool et au tabac.

CHAPITRE 7

Influences culturelles sur la consommation d'alcool, de tabac et de de drogues chez les Canadiennes

Par Manuella Adrian, Christiane Dini, Gina Stoduto et Lisa J. MacGregor

Une revue de la documentation scientifique révèle que, dans la plupart des pays du monde, l'usage d'alcool, de tabac et de drogues est différent pour les hommes et pour les femmes. En effet, non seulement moins de femmes que d'hommes consomment ces substances, mais les femmes qui le font les consomment en moins grande quantité, du moins en ce qui concerne l'alcool et le tabac. La proportion de femmes qui consomment ces substances et la quantité consommée varient suivant le pays. Pourtant, la consommation d'alcool et de tabac chez les hommes et chez les femmes de tous les pays était interdépendante ($n=0,67$, $p<0,0005$ pour l'alcool, et $p=0,3$, $p<0,05$ pour le tabac).

La population canadienne actuelle est composée d'individus originaires d'autres contrées, en commençant par l'arrivée des autochtones il y a 20 000 ans jusqu'à nos jours, où près de 20 p. 100 de la population actuelle est née à l'extérieur du pays. Des études menées au Canada, aux États-Unis, en Grande-Bretagne, en Israël, et dans d'autres pays caractérisés par une grande mosaïque culturelle (sur le plan de la langue, de la culture ou du pays d'origine) ont mis au jour des différences profondes en matière de consommation d'alcool, de tabac et de drogues selon l'appartenance culturelle. Des études menées auprès des populations à forte immigration révèlent que les immigrantes modifient leur consommation de substances par rapport ce qu'elle était dans leur pays d'origine. La nouvelle consommation est toutefois différente de la moyenne de la population du pays d'accueil, et ce, tant pour la consommation que pour les comportements connexes. La ressemblance croissante entre les comportements types des femmes et des hommes dans les pays d'accueil des immigrantes et l'usage accru de substances dans le but d'amoindrir les tensions ressenties par les immigrantes qui font face à des comportements différents de ceux de leur pays d'origine sont les raisons qui expliquent ces changements de comportements.

Une analyse des données canadiennes provenant de l'Enquête nationale sur l'alcool et les autres drogues (ENAAD) de 1989 a permis d'identifier les profils de comportements liés à l'usage d'alcool et de drogues chez les Canadiennes appartenant à différentes ethnies ou groupes culturels. Le profil compte 110 variables liées à l'usage de substances psychotropes, telles que le genre d'alcool ou de drogue utilisée, la quantité, la fréquence, les circonstances entourant la consommation, la boisson alcoolique préférée, les raisons qui poussent à boire ou à s'abstenir, et l'opinion sur les comportements acceptables en matière de consommation d'alcool ou de drogues. On a étudié ces comportements chez les Canadiennes qui affirment appartenir aux groupes ethniques ou culturels «canadien», français, anglais, allemand/néerlandais, irlandais, écossais, ukrainien/polonais, italien/portugais, et «autre» (chinois, juifs, et «autre»). Nous avons observé que les comportements liés à l'usage d'alcool, de tabac et de drogues varient suivant le groupe ethno-culturel. De plus, chaque groupe ethno-culturel se démarque de la moyenne nationale. Ainsi, les Canadiennes-françaises avaient une attitude moins favorable vis-à-vis de l'usage de drogues et d'alcool, tandis que les Canadiennes-anglaises avaient une attitude plus négative vis-à-vis de l'usage de drogues. Les Canadiennes-écossaises, quant à elles, avaient une attitude plus positive à l'égard de l'alcool et plus négative quant aux drogues, surtout les drogues illégales. Les Canadiennes-irlandaises étaient plus favorables vis-à-vis de l'alcool

et des drogues; les Canadiennes-allemandes néerlandaises étaient plus favorables à l'alcool et aux drogues. Les Canadiennes-ukrainiennes/polonaises étaient plus favorables à l'alcool, mais moins aux drogues et au tabac. Les Canadiennes-italiennes/portugaises étaient moins favorables à l'alcool et aux drogues illégales, mais plus favorables au tabac et aux drogues légales (seule la moitié des membres de ce groupe culturel consommaient des médicaments sur ordonnance alors qu'environ 90 p. 100 des femmes des autres groupes en consommaient). Les «autres» Canadiennes étaient moins favorables à l'alcool et aux drogues légales, mais plus favorables aux drogues illégales.

Afin de satisfaire les besoins particuliers des divers groupes culturels canadiens, les programmes d'intervention et de prévention de l'usage d'alcool, de tabac et de drogues, ainsi que de leurs effets nocifs doivent tenir compte de ces différences culturelles au sein de la population de Canadiennes.

CHAPITRE 8

Les autochtones canadiennes et l'usage de drogues psychotropes

par Kim Scott

Lorsque l'on compare les variables démographiques des femmes autochtones du Canada avec celles de leurs homologues masculins et celles de l'ensemble des Canadiennes, on est en mesure d'établir le contexte de l'usage abusif ou non de drogues psychotropes au sein des communautés autochtones. Comparativement aux hommes, les femmes autochtones courent un risque plus élevé de contracter des maladies ou de faire face à des problèmes sociaux. De plus, elles ont plus tendance à subir la violence de leur conjoint, à diriger des familles monoparentales, à subir l'inceste ou la violence sexuelle ou encore, une discrimination sexuelle institutionnalisée. Les femmes autochtones présentent un taux de chômage plus élevé que la moyenne de la population canadienne; elles ont moins tendance à se marier, à fréquenter les écoles secondaires ou à vivre au-dessus du seuil de la pauvreté.

Huit femmes autochtones sur dix ont vécu la violence de leur partenaire; cette proportion est de une femme sur dix chez l'ensemble des Canadiennes. Une enquête a révélé que 80 p. 100 d'un échantillon de femmes ont personnellement vécu la violence familiale, 44 p. 100 ont affirmé que l'alcool était souvent en cause, et 37 p. 100 ont affirmé que l'alcool était habituellement en cause.

Diverses études donnent une idée du taux d'usage ou d'abus de drogues psychotropes parmi les femmes autochtones. Une étude a révélé que la méthode de suicide la plus répandue chez les femmes autochtones de la Saskatchewan était l'empoisonnement causé par une surdose d'alcool ou de drogues. En conséquence, le taux de suicide parmi cette population (par 100 000 habitants) est 14 fois plus élevé que chez l'ensemble des Canadiennes. La mort violente est la cause de décès la plus fréquente chez les adultes autochtones. Cela est étroitement lié à l'usage abusif de drogues psychotropes, ce dernier étant l'un des facteurs les plus importants des problèmes de santé des autochtones. Plusieurs études semblent indiquer que l'alcool est la substance psychotrope dont abusent le plus les autochtones du Canada. En outre, les hommes ont plus tendance à en faire un usage abusif que les femmes.

La plupart des autochtones qui reçoivent un traitement de la toxicomanie sont des hommes, mais cette différence entre les sexes se resserre lorsque l'on se dirige vers l'ouest du pays. Les femmes autochtones, quant à elles, se voient forcées de choisir entre le traitement ou l'éducation de leurs enfants puisque aucun centre de traitement des communautés autochtones n'offre un service de garde d'enfants. De plus, il faudrait que les centres de traitement autochtones pour femmes tiennent compte de la physiologie de la femme : tenir compte de l'impact des règles, de la ménopause, de la grossesse, des fausses couches ou des avortements. Les organisations autochtones considèrent que toute femme autochtone, quel que soit son niveau de consommation d'alcool ou d'autres substances psychotropes, est sujette à l'usage abusif de drogues à un moment ou à un autre de sa vie.

L'abus d'alcool chez les femmes autochtones est un problème sérieux dont doivent tenir compte les programmes de traitement qui verront la jour à l'avenir. Les autochtones canadiennes présentent un taux de syndrome d'alcoolisme fœtal plus élevé que la moyenne de l'ensemble des Canadiennes. De plus, c'est surtout la femme célibataire, pauvre et isolée qui fait un usage abusif.

Nos connaissances sont très limitées pour ce qui est de faciliter la prise de conscience des femmes autochtones en matière d' amélioration de leur situation par la prise en main de leur vie.

La recherche menée auprès des populations autochtones est limitée. Les données ne sont pas suffisantes pour mesurer l'ampleur du problème. Il en résulte que la moyenne de l'ensemble des Canadiennes sert de point de comparaison, même si ces deux groupes diffèrent sur le plan du nombre de variables démographiques.

Il faut effectuer une analyse directe, valable, fiable et quantitative des taux de consommation des drogues psychotropes les plus en usage. Ces études doivent aussi tenir compte de l'âge, du sexe, de l'appartenance aux tribus, de la situation géographique et du statut socio-économique. Ces études devraient répondre à des questions précises, soit quel genre de programme est le plus susceptible d'avoir des résultats positifs chez la femme autochtone et quelle stratégie éliminerait les obstacles posés par la stigmatisation ou les institutions. Afin de répondre à ces questions, il faudrait que la recherche sur les autochtones soit menée avec leur consentement et leur participation totale, si elle n'est pas menée par la communauté autochtone elle-même, afin que ces travaux puissent déterminer le type de recherche le plus approprié à la situation des autochtones.

CHAPITRE 9

Usage de drogues légales et dépendance chez les Canadiennes

par Ellen Tabisz, Eva Janacek, Roberta Ferrence et Lucia Farinon

Le présent chapitre aborde l'usage de drogues psychotropes légales, c'est-à-dire les médicaments sur ordonnance et les médicaments en vente libre. La documentation scientifique indique que l'usage de ces drogues est généralement plus élevé chez les femmes que chez les hommes, chez les personnes âgées ou les personnes dont l'état de santé est précaire. La consommation de ces médicaments peut susciter tolérance et dépendance.

L'usage de ces médicaments repose sur l'attitude du médecin, lequel peut se faire une idée préconçue du comportement de la femme lorsque celle-ci est malade. Il peut aussi reposer sur l'attitude du client ou de la cliente qui cherche à se soigner sans aide extérieure avec ces médicaments. L'usage de drogues psychotropes chez la femme peut être motivé par la présence de troubles psychosociaux ou psychiatriques, d'un environnement familial instable, de la violence physique, d'une mauvaise estime de soi, de l'usage abusif ou non de drogues durant jeunesse, de la recherche de sensations fortes ou d'une relation parentale dysfonctionnelle.

Les femmes qui vivent la violence dans leur relation familiale peuvent se tourner vers ces drogues pour composer avec leur situation. Le groupe de femmes qui font un usage abusif de drogues psychotropes en vente libre présente un niveau plus faible d'éducation, un taux de chômage plus élevé, souffrent d'un plus grand nombre de troubles physiques ou mentaux chroniques, et se sentent impuissantes à l'égard de la vie.

Les personnes âgées courent plus de risques de s'attirer les réactions négatives de leur entourage, réactions suscitées par la prise de médicaments en vente libre, étant donné la quantité qu'elles consomment. En effet, les deux tiers des personnes âgées de plus de 60 ans consomment au moins un médicament par jour. Puisque ces personnes prennent également des médicaments sur ordonnance, les risques d'interaction entre les drogues augmentent. Il y a aussi un risque d'usage abusif d'analgésiques sans narcotique comme l'acétaminophène ou les anorexiques diménhydrinate ou phénylpropanolamine. Les effets néfastes de ces médicaments chez les femmes sont notamment troubles de la reproduction, effets nocifs sur le fœtus et problèmes en matière d'aptitudes parentales.

L'Enquête nationale sur l'alcool et les autres drogues (ENAAD) indique que l'usage de tranquillisants est plus élevé chez les femmes que chez les hommes, et ce, dans toutes les catégories d'âge, à l'exception des plus jeunes (15 à 24 ans) pour qui on n'a pas observé de différence considérable. L'usage augmente avec l'âge. Les femmes âgées de 45 à 64 ans se placent au premier rang (18 p. 100) et les hommes âgés de 15 à 24 ans, au dernier rang (moins de 1 p. 100).

Dans le cas des opiacés, nous avons observé des différences notoires en fonction du sexe. Les femmes âgées de 25 à 64 ans présentent un taux de consommation d'opiacés beaucoup plus élevé que les hommes du même âge. L'usage de somnifères, quant à lui, augmente énormément avec l'âge, tant chez les femmes que chez les hommes. Ce sont les hommes et les femmes âgés de 65 ans et plus qui en font le plus grand usage, mais celui-ci est beaucoup plus élevé chez les femmes âgées de 15 à 24 ans et de 45 à 64 ans.

L'usage de tranquillisants, de somnifères et d'opiacés chez les femmes varie selon leur état civil. En effet, la consommation est plus faible chez les femmes célibataires, augmente chez les femmes mariées, divorcées ou séparées, et atteint un sommet chez les veuves. Pour ce qui est des hommes,

seul l'usage de somnifères varie en fonction de l'état civil. L'usage de tranquillisants et de somnifères diminue lorsque la scolarité augmente, chez les hommes aussi bien que chez les femmes. Ces dernières consomment plus de tranquillisants que les hommes, et cela, dans toutes les catégories de revenus.

En ce qui concerne la dépendance aux drogues psychotropes sur ordonnance, les femmes semblent être deux fois plus dépendantes que les hommes dans toutes les catégories d'âge, d'état civil, de scolarité ou de revenu. L'usage d'AAS (aspirine) est considérablement plus élevé chez les femmes de toutes catégories; l'usage des pilules amaigrissantes est plus élevé chez les femmes, à l'exception des veuves et des femmes à faible revenu. L'enquête ne relève pas de différences considérables en fonction du sexe de l'usage d'analgésiques narcotiques comme la codéine, la morphine ou le démérol. Les femmes consomment plus de somnifères que les hommes seulement dans la catégorie de revenu élevé et de faible scolarité; l'usage d'analgésiques avec ou sans narcotiques est associé à une scolarité plus élevée.

CHAPITRE 10

Différences du taux de victimisation liée à l'alcool, selon le sexe : analyse des résultats de l'Enquête nationale sur l'alcool et les autres drogues, 1989

par Florence Kellner, Shirley Mills, Suzanne Hill et Ikuko Webster

La documentation scientifique sur la victimologie (l'état de victime) a relevé les caractéristiques des victimes d'actes criminels, soit l'âge, le sexe, le mode de vie ou l'endroit où la violence a lieu.

Les jeunes, les femmes, les personnes à revenu élevé (larcins) et les personnes à faible revenu (crimes violents) tiennent le plus souvent le rôle de victimes. Le comportement de la victime est également perçu comme important, mais cette hypothèse ne tient pas compte de la différence entre la force de la victime et celle de l'agresseur. L'alcool tient également une place de premier plan, surtout dans le cas des attentats, des accidents fatals de la route, des suicides, des insultes, du harcèlement, des altercations dans une taverne, etc.

Les femmes ne sont pas victimes d'un nombre aussi élevé d'actes violents que les hommes, mais elles sont victimes de violence conjugale, de viol, de harcèlement et des problèmes découlant de l'ivresse d'une autre personne. Les femmes qui boivent sont probablement plus souvent victimes que celles qui ne boivent pas.

La documentation scientifique signale un lien entre le sexe, l'alcool et la victimisation : habituellement, l'agresseur, au même titre que la victime, est jeune, de sexe masculin et vit dans une collectivité urbaine. Les femmes subissent la violence sexuelle et conjugale plus souvent que les hommes. Les hommes, quant à eux, sont plus souvent victimes de violence physique ou de vol et de violence interpersonnelle liée à l'alcool. Les problèmes d'alcool du conjoint sont un facteur de prédiction important des risques de violence à l'endroit de la conjointe. De plus, si elle boit, une femme court des risques plus élevés de devenir une victime et, au contraire de l'homme, le fait de fréquenter un bar ou une taverne régulièrement augmente ses risques de devenir une victime.

L'analyse multivariée des 11 634 réponses (6 343 femmes et 5 291 hommes) nous a permis de mettre en relief les facteurs, comme le sexe, les problèmes financiers ou familiaux, qui favorisent la violence découlant de problèmes d'alcool d'autres personnes, que cette violence soit mineure (disputes, insultes) ou grave (accidents de voiture, violence physique). On a réduit l'échantillon à 6 474 sujets après avoir pondéré l'échantillon et éliminé les questionnaires incomplets de l'Enquête nationale sur l'alcool et les autres drogues (ENAAD).

Cette analyse a servi à créer un barème de victimisation qui permet de relever un certain nombre de conséquences sociales.

L'analyse des données du ENAAD concernant les femmes permet de cerner les facteurs de prédiction de la prévalence et du type de victimisation qui déterminent l'importance relative des caractéristiques individuelles influant sur les risques de victimisation. Les principales questions abordées dans le présent chapitre sont : l'examen des conséquences victimologiques liées à l'alcool permet-il de cerner les segments de la population qui courent des risques d'être victimes de la consommation d'alcool d'autres personnes? Jusqu'à quel point la population canadienne est-elle exposée aux conséquences négatives de la consommation d'alcool des «autres»? Y-a-t-il des différences quant aux

genres de conséquences victimologiques liées à l'alcool, selon le sexe? Jusqu'à quel point le sexe détermine-t-il l'intensité totale et le genre de victimisation?

Nos résultats sont comparables à nos prédictions, d'après l'examen de la documentation scientifique. Ils ont démontré que les problèmes des femmes sont surtout de nature domestique et financière tandis que ceux des hommes sont plutôt des dommages physiques causés par des accidents de la route ou des agressions. La vie amoureuse des femmes semblent prendre une grande place tandis que celle des hommes est plus segmentée. Le sexe ne semble pas influer sur la victimisation découlant de la consommation d'alcool.

Les études antérieures portant sur la victimisation due à l'alcool ont désigné la famille comme milieu où les femmes vivaient le plus de violence. C'est également ce que nous avons constaté. Nous avons aussi constaté que les femmes qui boivent dans des situations précises ont plus de chances de subir la violence que les hommes, de subir des insultes et de prendre part à des disputes. Cependant, les hommes qui boivent une grande quantité d'alcool dans certaines situations ont plus de chances d'être agressés. Il semblerait que le sexe et l'état civil jouent un rôle de moins grande importance en matière de victimisation liée à l'alcool que ce que l'on avait prédit. Les probabilités que la victimisation prenne fin augmentent avec l'âge. Les problèmes liés à l'alcool chez les proches étaient un facteur de prédiction important des risques de victimisation liée à l'alcool. Les différences de victimisation liée à l'alcool dues au sexe semblent être également associées à d'autres facteurs. Lorsque l'analyse tient compte de ces autres facteurs, les différences dues au sexe disparaissent.

CHAPITRE 11

Prédicteurs des niveaux de consommation d'alcool chez les Canadiens et les Canadiennes

par June Chaikelson

La documentation scientifique sur l'usage abusif ou non d'alcool signale que l'alcoolisme est beaucoup moins fréquent chez la femme que chez l'homme. L'Enquête nationale sur l'alcool et les autres drogues (ENAAD, 1989) a confirmé cette hypothèse. En effet, moins de femmes que d'hommes buvaient et, celles qui le faisaient, buvaient en moins grandes quantités que les hommes. Par rapport aux hommes, les femmes sont plus souvent abstinentes ou sont d'anciennes consommatrices occasionnelles d'alcool. La proportion de celles qui avaient déjà consommé de l'alcool régulièrement ou qui en consomment à l'heure actuelle était plus faible. Des techniques de régression multiple ont servi à l'analyse des données de l'ENAAD. L'enquête se fonde sur les renseignements recueillis auprès de 11 634 répondants (6 343 femmes et 5 291 hommes). On a réduit l'échantillon à 4 848 sujets après avoir pondéré l'échantillon et éliminé les questionnaires incomplets. On a fait appel à des analyses de régression multiple distinctes pour les hommes et pour les femmes, pour les personnes mariées (échantillon composé d'hommes et de femmes mariés, âgés de 25 ans et plus), et pour un échantillon de jeunes (hommes et femmes âgés de moins de 25 ans).

L'analyse a indiqué que les femmes plus scolarisées, qui détenaient un emploi, et dont le revenu était plus élevé buvaient en plus grandes quantités. L'état de santé était également un facteur de prédiction important de consommation d'alcool : les femmes dont l'état de santé était précaire buvaient moins et les femmes plus stressées buvaient plus. Chez les hommes, les plus jeunes, les moins scolarisés, ceux qui détenaient un emploi et dont le revenu était plus élevé buvaient en plus grande quantité. L'analyse a fait ressortir que la différence principale entre les hommes et les femmes en matière de quantité d'alcool consommé, se situait sur le plan de la scolarité. Ainsi, les femmes dont la scolarité est plus élevée consomment plus d'alcool. Chez les hommes, la relation est différente : une scolarité plus élevée est associée à une consommation plus faible d'alcool. Le «stress» joue un rôle dans la consommation d'alcool des femmes mariées âgées de 25 ans et plus, et des adolescents de sexe masculin; mais chez les femmes âgées de moins de 25 ans et les hommes adultes, l'influence est minime.

CHAPITRE 12

Prévention et traitement de l'abus de drogues psychotropes chez les femmes

par Lynn Lightfoot, Manuella Adrian, Gillian Leigh, Joyce Thompson

Dans le présent chapitre, nous décrivons un modèle conceptuel qui permet de catégoriser la promotion de la santé ainsi que les programmes de prévention et de traitement dans le domaine de l'usage abusif de drogues psychotropes (y compris l'alcool, le tabac et les autres drogues). Les modèles conceptuels tiennent rarement compte des différences entre les hommes et les femmes, que ce soit sur le plan du développement ou de la présentation des symptômes. Les femmes qui font un usage abusif de drogues psychotropes sont issues plus souvent que les hommes d'une famille dysfonctionnelle où il y avait usage abusif de drogues. De plus, elles ont plus souvent un conjoint alcoolique et les enfants sont, plus souvent qu'autrement, sous sa responsabilité. Elles ont moins de chance que les hommes de décrocher un emploi à l'extérieur du foyer familial et ont moins de compétences sur le marché du travail. Elles ont un accès restreint aux services de soutien social conventionnels, sont plus souvent dépressives et anxieuses et ont moins confiance en elles que les hommes qui font un usage abusif de drogues psychotropes. Les femmes ont plus tendance que les hommes à présenter des troubles affectifs. Les hommes ont plutôt des troubles antisociaux de la personnalité.

Les femmes ont à consommer moins longtemps que les hommes avant que les problèmes physiologiques ou autres ne fassent leur apparition. La consommation pathologique est liée aux événements capitaux de leur vie, comme un divorce ou un accouchement. La violence sexuelle comporte aussi un aspect d'importance étiologique. Les critères de diagnostic de la toxicomanie utilisés à l'heure actuelle auprès des femmes ne tiennent pas compte de l'étiologie féminine. De plus, il arrive souvent que les spécialistes n'arrivent pas à diagnostiquer les problèmes liés à l'usage abusif de drogues. Les différences biologiques, comme le pourcentage relatif d'eau dans l'organisme (plus faible chez les femmes que chez les hommes), expliquent pourquoi il leur faut consommer une moins grande quantité d'alcool avant de ressentir des problèmes.

La plupart des thérapies ont été concues par et pour les hommes. Pourtant, les femmes ont besoin de programmes pensés spécialement pour répondre à leurs besoins particuliers en offrant, par exemple, des services de garde d'enfant pendant la thérapie ou des services de transport. Les caractéristiques des diverses thérapies sont : psychothérapie, modification du comportement, pharmacothérapie, groupe d'entraide, thérapie conjugale. Déterminer lesquelles de ces thérapies conviennent particulièrement aux femmes n'est pas tâche facile car les critères d'évaluation ne sont pas toujours clairement établis. Ce n'est que durant la dernière décennie que l'on a commencé à s'intéresser aux différences entre les sexes.

Entre 1987 et 1990, on a évalué 211 interventions auprès des femmes. Au cours de la décennie écoulée, seules sept études, dont deux menées au Canada, ont fait appel à la technique d'assignation aléatoire, méthode la plus précise pour déterminer les répercussions de l'intervention chez les femmes. Ces études n'ont pas relevé de différences selon le sexe. Cependant, des sept études comparatives, quelques-unes ont signalé des différences selon le sexe. Ce sont les études cliniques ou descriptives qui font le mieux ressortir les effets des différences selon le sexe.

Le pronostic chez les femmes, en dépit d'une pathologie plus grave, serait au moins le même que chez les hommes.

CHAPITRE 13

Traitement de la toxicomanie : opinion des femmes et usage qu'elles en font

par Lynn Lightfoot, Manuella Adrian, Gillian Leigh, Joyce Thompson

L'Enquête nationale sur l'alcool et les autres drogues de 1989 permet de déterminer le niveau de risque chez les femmes : quelles drogues consomment-elles, à quelle fréquence, en quelle quantité, dans quelles circonstances, quels problèmes découlant de leur propre abus signalent-elles, découlant de l'abus de leur entourage, de l'abus des personnes faisant partie de leur réseau social ou de la collectivité. Même si les femmes consomment moins de drogues, certains problèmes sont plus fréquents chez elles que chez les hommes. Les femmes dont l'état de santé est précaire, qui vivent un stress plus intense et qui reçoivent moins d'aide de leur famille ont plus tendance à consommer des drogues. Face aux problèmes liés à l'usage abusif de drogues psychotropes, les femmes semblent réagir plus ou moins comme le font les hommes, suivant les comportements. Seules trois pour cent d'entre elles rapportent avoir utilisé certains services de traitement et près de la moitié ont suggéré à une autre personne de se faire soigner. Dans le présent chapitre, nous décrivons les différences associées à la scolarité, à l'état civil, à la présence d'un enfant de moins de 15 ans à la maison, au genre d'emploi et au revenu familial des femmes. Celles-ci semblent se tourner vers les services d'entraide, pour elles-mêmes ou pour autrui. Les réponses à l'enquête et les données administratives du réseau hospitalier indiquent que 7,4 millions de femmes boivent de l'alcool et 200 000 rapportent avoir suivi un traitement pour des problèmes liés à l'alcool; 1,8 millions rapportent avoir consommé des drogues et 50 000 déclarent avoir suivi un traitement de la toxicomanie.

CHAPITRE 14

Les Canadiennes et les drogues psychotropes : aperçu et conséquences politiques

par Judith Blackwell, Wilfreda Thurston et Kathryn Graham

La recherche, le traitement et autres interventions en toxicomanie ont eu pour conséquence de médicaliser les problèmes parce qu'ils définissent les gestes de la vie quotidienne comme étant du domaine médical. La consommation par les femmes de drogues psychotropes à des fins non médicales est considérée comme un acte purement individuel qui ne tient pas compte des conditions socio-économiques des femmes. Notre analyse des politiques en matière de drogues psychotropes révèle qu'on ne devrait pas accorder une importance fondamentale à la psychopharmacologie de ces drogues, mais on devrait plutôt s'intéresser au contexte socioculturel au sein duquel les problèmes se manifestent, s'aggravent ou s'améliorent. Les sujets abordés dans le présent chapitre sont notamment la médicalisation des problèmes féminins, la consommation d'alcool et de médicaments psychotropes sur ordonnance chez les Canadiennes âgées, le rôle de la consommation de drogues psychotropes dans la grossesse et l'accouchement normaux, les problèmes liés à la consommation de drogues psychotropes chez les femmes qui vivent dans les collectivités autochtones et la mise sur pied de services souples à l'intention des femmes qui seraient axés sur leurs besoins particuliers et aisément accessibles à cette population.

Notre opinion est qu'il faut réduire les conséquences néfastes des problèmes liés à l'alcool et aux autres drogues chez les femmes en faisant appel à une stratégie générale qui vise à améliorer leur bien-être socio-économique. Cette stratégie doit s'opposer aux obstacles auxquels les femmes se heurtent justement parce qu'elles sont des femmes. Les obstacles les empêchent de jouer pleinement leur rôle et de participer de façon satisfaisante aux institutions sociales qui donnent à chacun sa valeur propre. Ainsi, elles pourront avoir du succès, ce qui leur permettra de s'engager pleinement et de s'exprimer de façon valorisante.

CHAPITRE 15

Enquête nationale sur l'alcool et les autres drogues, 1989 : notes techniques

par Marc Eliany

L'Enquête nationale sur l'alcool et les autres drogues (ENAAD, 1989) est la première enquête canadienne à s'intéresser particulièrement aux problèmes précis de l'usage d'alcool et de drogues, comme il est démontré en comparaison avec les facteurs inclus dans les enquêtes antérieures.

Le ENAAD visait à documenter et analyser les pratiques liées à l'usage d'alcool et de drogues : les modes de consommation à l'échelle nationale ou régionale; les motifs qui poussent une personne à consommer ou à s'abstenir; les circonstances dans lesquelles la consommation a lieu; le rôle de la famille, de l'entourage et de la collectivité par rapport à ces comportements; les conséquences de la consommation; les interventions suscitées par ces effets et les attitudes et opinions du public face à l'usage de ces drogues psychotropes.

Les données de l'enquête proviennent d'un entrevue téléphonique menée auprès d'un échantillon de 11 364 Canadiens, dont 6 343 femmes, âgés de 15 ans et plus et originaires des dix provinces. La taille de l'échantillon nous permet d'obtenir des estimations à l'échelle nationale ou provinciale. Le pourcentage de réponse est de 79 p. 100. Les motifs justifiant un refus de répondre sont : absence pendant la période de l'enquête, maladie, refus pur et simple et barrière linguistique. La cueillette et le traitement des données ont été réalisés par Statistique Canada. La complexité du schéma d'échantillonnage (sélection des répondants par étapes multiples) a influé sur l'estimation et le calcul des variances, ce qui a exigé des corrections pondérales. Les données de l'échantillon ont été pondérées selon le sexe et l'âge du répondant et sa province d'origine, de manière à ce qu'elles correspondent aux données démographiques de la population totale du Canada au moment de l'enquête. Certaines analyses statistiques, telle la régression linéaire ou logistique, l'analyse de variance ou les estimations des taux et proportions ont également exigé des corrections statistiques.

On peut s'interroger sur la validité des données obtenues directement des répondants dans le cadre d'une enquête sur l'alcool et les drogues, étant donnée la stigmatisation de ces comportements. Cependant, des études ont démontré que les réponses étaient passablement précises lorsqu'elles étaient recueillies auprès de répondants sobres dans des circonstances confidentielles. De plus, une sous-estimation de la consommation était limitée dans nombre de circonstances, quoique la consommation obtenue par enquête atteignait au plus 40 à 60 p. 100 de la consommation d'après les chiffres d'affaires provenant des points de vente. L'usage de mesures multiples auprès de divers aspects de la consommation et d'autres comportements liés aux drogues psychotropes aurait tendance à diminuer les erreurs causées par la sous-estimation d'une variable.

CHAPTER 1

History of Canadian Women's Use of Alcohol, Tobacco and Other Drugs

Lorraine Greaves

Drug and alcohol abuse among women is a political issue, linked to gender roles, power, ambivalence, and hidden angers and fears.

(Gomberg, 1982:21)

This chapter traces the historical patterns of women's consumption of and reactions to tobacco, alcohol, and licit and illicit drugs in Canada. Women's patterns of consumption and abuse, their organized response to substance abuse, and also, social reactions to women's substance abuse are all important indicators of women's status and the view that society has had of women at various points in Canadian history. Certain patterns of substance abuse (such as those leading to intoxication) interfere with a woman's ability to carry out approved roles, while other patterns (such as those involving self-medication) may actually assist women in carrying out their expected social roles.

Overall, women's use of and reactions to tobacco, alcohol and other drugs has been largely ignored, both in the scientific literature and by professionals in the medical and therapeutic communities (Kalant, 1980, Chapter 1). Only in the last 20 years has women's use of substances been recognized in Canada as worthy of study and social and medical concern. Furthermore, only in the last decade has it been recognized that women's tobacco use is substantially different from that of men, and that gender has an impact on smoking habits. It has often been noted that men consume more illicit drugs, alcohol and tobacco than do women (Kalant, 1980, Chapters 1 & 12; Eliany, 1989; Gomberg, 1982), and that women consume more licit drugs than do men. However, the impact of cultural, social, religious and economic factors, and of historical events and contexts on the differing substance use patterns of women and men, has not been systematically researched.

The "androcentrism," or male-centredness, of the historical view of substance abuse is reflected elsewhere. Women's issues in general, and women's health issues in particular, are only now being considered, and the impact of gender, sexism and women's inequality acknowledged. While it is true that early activists in the women's movement put forth positions on these issues that have, in some cases, been significant to the development of public policy in Canada, it is only recently that the additional issue of sexism in research and professional practice has been addressed. This shift, if sustained, will benefit women by allowing and promoting the development of gender-sensitive research, policy, and prevention and treatment programs for substance abuse.

Early Use of Tobacco, Alcohol and Other Drugs

No direct information is available on the development of women's patterns of alcohol, tobacco and other drug use in Canada prior to the twentieth century. However, it is possible that the few references to the development of such practices in both Europe and the United States may have had similar echoes in Canada, if attitude changes regarding women were diffused through the European settlement and by subsequent waves of Canadian immigration.

It is widely believed that before the European settlement of Canada, there was no use of alcohol or psychotropic drugs by native peoples. There was, however, some use of tobacco leaves.

Tobacco

Fifteenth- and sixteenth-century European explorers to North, Central and South America encountered native women and men who smoked tobacco leaves in pipes, inhaled tobacco in the form of snuff, and used it in various ways for medicinal and religious or shamanistic purposes (Corti, 1931; Gritz, 1980). The tobacco so employed was often of low nicotine content (Smart, 1983:4). It is widely assumed that such practices were pursued for thousands of years prior to the arrival of Europeans.

Tobacco use was introduced into Europe by explorers who returned from North America with tobacco leaves. Tobacco's curative powers, with respect to such conditions as the "diseases of women," were widely promoted by the sixteenth century.

By the seventeenth century, smoking had become fashionable in England despite the opposition of King James I. Further, "a new race of physicians was springing up by day – cunning peasants, crazy old women, simple-minded girls, who persuaded the sufferers to try the 'holy' antidote which they had found so beneficial in their own case" (Corti, 1931:79).

Sale of tobacco was either prohibited, severely punished or limited to apothecary shops and sold on prescription only (Corti, 1931, Chapters 5–6). Eventually, however, both church and state accepted tobacco use, either implicitly or explicitly. Pipe smoking gradually gave way to the inhalation of snuff, then to the smoking of cigars and, eventually, cigarettes.

Tobacco use remained controversial, with opponents pointing out how it exploited the lower classes and gave profits only to companies and governments. Other opponents argued that tobacco use was harmful to the body,

although stronger counter-arguments in favor of its protective and healing powers prevailed.

Women and Tobacco Use

Historically, racism, sexism and classism affected attitudes toward tobacco use. Critics opposed to the idea of women smoking argued that the habit was "unfeminine" (it was dirty and smelly). In spite of such opposition, the belief slowly grew over the course of two centuries that women should have an equal right to smoke, and by the twentieth century this attitude had taken hold. The argument for equality was put forth by both women and men. One male doctor writing in the eighteenth century stated:

> *... tobacco is invaluable. ... I will merely state at the outset that it is a glorious venture when a woman takes heart to smoke a pipe of tobacco. Her charming sex has an equal right with men.*
>
> *(Corti, 1931:197)*

In stark contrast with this viewpoint, the temperance leagues of the nineteenth century linked tobacco use with the victimization of women. They held that it corrupted men and led them away from their responsibilities to women. However, while tobacco use by women had been linked to health problems and equated with immorality and insanity, by 1920 it came to symbolize emancipation and an "exuberant liberalism" to its proponents (Gritz, 1980:492).

Early Patterns of Substance Use

It is difficult to determine the exact nature of the consumption of alcohol, tobacco and other drugs among Canadian women during the early colonial and pioneer era. The male-centred historical record limits the understanding of women's roles and substance use prior to the development of the temperance movement. While it is generally acknowledged that the early settlers and Indian men indulged in much heavy drinking, "nearly all early records of drinking involve men. Accounts of female drinking or drunkenness from before 1850 are almost non-existent" (Smart & Ogborne, 1986:11).

A few limited accounts of the drinking and drunkenness of native women – as opposed to European women – do exist (Smart & Ogborne, 1986:11). This slight difference in the recorded history may reflect that era's racism and moralistic attitude toward women and drinking, which led to the lack of acknowledgment of alcohol use among white women.

The Early Use of Psychotropic Drugs

As in the case of alcohol, it was European settlers who introduced psychotropic drugs to native peoples in Canada. While several psychotropic plants besides tobacco probably grew in the wild, they were apparently not used for mind-altering purposes.

By the late eighteenth century, patent medicines started to be available in Canada and were usually imported from Europe and the United States. These medicines were advertised as cures for a wide range of ailments from coughing to asthma, and from cholera to venereal disease. Usually, it was believed that "men's diseases" (including venereal disease) and "women's diseases" (fatigue and general

weakness) were completely different, and thus different patent medicines were developed to treat them.

> *Not much is known about the content of the medicines sold during the 1800s. Since there was no requirement that labels state the contents, few manufacturers bothered. While actual analyses of the contents are often not known, it is likely that most of those in liquid form contained alcohol (up to 70 per cent alcohol) and that many of the painkillers contained morphia or laudanum (both opiates) or cocaine.*
>
> *(Smart, 1983:5)*

The manufacture and use of these medicines in Canada grew substantially until the passage of the first drug controls under the *Proprietary and Patent Medicines Act* in 1908. By this time, the use of cocaine as an ingredient in drinks, medicines, pills, cigarettes and cough syrups was widespread, judging from extensive advertisements and their wide availability. Ironically, some of these medicines, which were addictive, were promoted as cures or tonics for people addicted to alcohol, opium and tobacco.

According to Gomberg (1982:11), women were the largest group of consumers of opiates in the form of patent medicines. Halas (1979:14) estimated that, in the late nineteenth and early twentieth centuries, three times as many women as men used opium. Concerned about high alcohol content, female temperance activists objected to the use of patent medicines. Nevertheless,

> *[i]t is an ironic footnote to history, but while women were fighting Demon Rum with such enthusiasm, many women – possibly including temperance workers – were sustaining themselves on opiate-laced tonics.*
>
> *(Gomberg, 1982:19)*

Eventually, members of the medical profession began to question the curative claims of advertisers promoting the use of opiate-filled medicines. This contributed to the move toward legal controls. Opiates thus became less available to women in the form of over-the-counter tonics. At this time, however, women began to acquire opiates through doctor-prescribed treatments (Gomberg, 1982:15). In this manner, the phenomenon of iatrogenic drug addiction, or addiction resulting from medical intervention (called "medical addiction"), developed among women. This phenomenon was not to be systematically addressed until several decades later.

Early Reactions to Substance Abuse in Canada

Anti-Alcohol Reactions

The early temperance movement in Canada was established by white male Christian revivalists (Methodists and Baptists, primarily) around 1830 (Smart & Ogborne, 1986:18). These societies were anti-liquor and anti-tavern. They were racist and sexist in their rules of membership. "Negro" men and native Indian men were not allowed to join, but were encouraged to form their own societies (Smart & Ogborne, 1986:19). Women were excluded altogether, since it was considered "unladylike" for women to discuss drinking.

By the late nineteenth and early twentieth centuries, women had formed their own temperance groups, and had come to dominate the temperance movement in English Canada. Organizations such as the Women's Christian Temperance Union (WCTU) developed strong platforms promoting not only abstinence from alcohol, but also social reforms of other types. The WCTU (whose members

were mainly, but not exclusively, anglophone, rural, Protestant and middle class) functioned, in fact, as a feminist organization promoting women's right to vote as a primary goal.

Although it is best known for its stand on alcohol, the WCTU had a large number of other interests. It placed a great deal of emphasis on women's suffrage and helped to get votes for women in Canada. Indeed, some of the late WCTU leaders, such as Nellie McClung, were more interested in this aspect than any other. In 1929, four of the five women who took the case declaring women to be "persons" to the Privy Council were WCTU members (Smart & Ogborne, 1986:21).

The WCTU adopted positions on other women's issues. The organization advocated the establishment of women's courts, private hearings for legal cases involving husbands and wives, corporal punishment for wife-beaters, dress reform for women and protective labor legislation for hired household servants (McKee, 1927). It also brought attention to the victimization and powerlessness of women (and children) resulting from male drinking, male violence, wife battering and family disorganization.

In Quebec, the temperance movement never enjoyed the same support and success that it did in English Canada, primarily because the Catholic Church hierarchy approved of moderate drinking and did not promote abstinence (see Chapter 3). Even in English Canada, considerable religious debate took place among members of Protestant denominations regarding the strength of Biblical support for total abstinence. This debate eventually limited the spread of the temperance movement and contributed to the failure of Prohibition in Canada.

The temperance movement in Canada was influenced by the temperance movement in the United States. The activity of the U.S. women's temperance unions was motivated at first by the belief that women were morally and spiritually superior to men. Inspired by such beliefs, the movement grew and eventually promoted not only women's suffrage or right to vote, but also the liberalization of divorce laws (Levine, 1980, Chapter 2). By the late nineteenth century, the movement had developed aims that were clearly in line with those of the feminist movement. Prominent feminists, such as Elizabeth Cady Stanton, Amelia Bloomer and Susan B. Anthony, overtly linked the evils of liquor to women's oppression (Levine, 1980:50). There were debates among women temperance advocates regarding what priority the feminist and temperance agendas should be given. The two agendas, however, became linked, just as they were linked together in Canada. The liberation of women came to be seen as a crucial goal that could not be accomplished without first reducing the victimization that women suffered as a result of the alcohol abuse of others. (It is interesting to note that, in response to the work of women's temperance organizations, liquor industry owners in the United States mounted a campaign against women's suffrage. Clearly, the liberation of women was held to threaten the vested interests of liquor industry owners [Levine, 1980:60].)

In the United States, parallel temperance and Prohibition movements developed according to the agenda of big business owners interested in controlling the liquor industry. According to Levine (1983), the capitalist establishment in the United States wanted more sober, and therefore more efficient, workers. They sought to eliminate the saloon, which functioned as a meeting place and a site for union organization. The consumption

of liquor was also held to threaten middle-class family life which, with its rigidly defined gender roles and division of labor, was critically important to the capitalist economy (Levine, 1980:32–33).

Although the capitalist establishment in the United States had at first backed the Prohibition movement, it eventually called for the repeal of Prohibition laws. The establishment reversed its stand for a number of reasons: tax revenue generated from the sale of liquor would relieve the tax burden that existed on big business at that time; creating employment through a revived liquor industry would help end the Depression; and the legalized sale of alcohol would stop the spread of "lawlessness" (i.e., bootlegging) (Levine, 1983:196).

Smart and Ogborne (1986:34–35) suggest that the decline of the temperance movement in Canada and the United States resulted from increased urbanization, increased non-Protestant European and Asian immigration, and the eventual failure of Prohibition. In addition, feminist leaders such as Nellie McClung left the temperance movement to pursue more diversified political and feminist goals (see Chapter 2).

Anti-Tobacco Reactions

In Canada, organizations such as the WCTU were also extremely concerned about the use of tobacco ("the cigarette evil") at home and abroad. The opposition to cigarette smoking and cigarette sales to minors had become part of the platform of the WCTU by the turn of the century, and the goal of eliminating tobacco use was fought for in various ways. The organization's activities had a profound, though temporary, effect on the development of legislation and public policy in Canada in the early years of this century.

By 1909, for example, the WCTU had been consulted by cabinet, had had bills submitted to it for approval, and was attributed with the power to "turn out a Government." The WCTU credited itself with "frightening" the Tobacco Trust into spending $20,000 to win an anti-cigarette campaign (McKee, 1927:82). The various unions across Canada had aligned themselves with a coalition of temperance groups to support the unsuccessful federal anti-cigarette legislation of 1903 and 1904. This legislation would have imposed a total ban on cigarette importation and manufacture. (In the United States, several states did create laws prohibiting the sale of tobacco, but the last of these laws was repealed in 1927 [Corti, 1931:266].)

The "tobacco evil," considered to be "the twin of the liquor evil" by the Canadian WCTU (McKee, 1927:115), ultimately became associated with a range of social problems. The use of tobacco was viewed not only as a threat to health, but also as one of many indicators of moral decline. In the final analysis, later anti-temperance reactions may have been in response to the overstated "moral" implications of tobacco and other substance abuse (Smart & Ogborne, 1986:29–30).

The anti-cigarette movement in Canada and the United States was eclipsed by the First World War. By 1919, the WCTU felt forced to concentrate its activities on the Prohibition of alcohol. According to McKee,

> *[l]ittle did we know what a body blow the war would give to the struggling reform! It fairly asphyxiated the public conscience, where tobacco was concerned, and it levelled the one-time barrier between the cigarette and women.*
>
> *(1927:98)*

As well, the general social changes promoting the emancipation of women, the attaining of women's right to vote (federally), and the loosening of social mores of the 1920s all helped to weaken the anti-tobacco movement. The year 1919 not only marked the end of an important era in women's organized response to the use of tobacco; it also marked the beginning of significant cigarette consumption among women in Canada. Cigarettes were increasingly available, and advertisements for manufactured cigarettes promoted the product as more "ladylike" than cigars or pipes. By the 1920s, cigarette smoking had become a symbol of female emancipation, modernity and a "new morality."

Anti-Narcotics Reactions

There was an organized response to the abuse of narcotics in the early part of this century, resulting in the passage of *The Opium and Drug Act* of 1908. After 50 years of legal activity, this act outlawed the sale and use of opium in Canada. Religious leaders and temperance workers had viewed opium as a dangerous substance, similar to alcohol. Racism, however, was also a considerable factor in the concern about opium use among Chinese men in British Columbia (opium was initially brought to Canada through the Chinese community) and the potential corruption of white women by these men (Smart, 1983:12-13).

Prior to 1900, there was no public agreement about the risks associated with opium use. Some felt that opium was less dangerous and debilitating than alcohol, and that it led to far less victimization of women. Others felt that opium smokers were a "better class" of people than were drinkers. The major thrust behind the anti-opium crusade was fuelled by the understanding that opium smoking was mainly the habit of Chinese men, and the belief that it was suspect on that basis alone.

Around 1900, organizations such as the WCTU began to express concern about opium and other narcotics, and various women leaders campaigned against their use. Most notable among them was Judge Emily Murphy, one of the "famous five" in the "Persons Case" and author of *The Black Candle* (1922). Murphy explicitly noted that much of the usage of opium involved West Coast Chinese men. She expressed concern about the potential risk of white women being drawn into drug use. Her stereotype of the drug user was racist; it usually consisted of an Asian or black man who corrupted white women.

Displaying an attitude typically held by reformers until about 1940, Murphy also promoted the image of the drug user as a "dope fiend" not worthy of treatment (Smart, 1983:20).

Many reformers and lobbyists of the era also linked prostitutes ("fallen women") to narcotic abuse. These reformers displayed reactions similar to their indignation regarding women's use of alcohol and tobacco, which they believed prostitutes helped encourage. In fact, many contemporary anti-drug lobbyists still link prostitutes to the current abuse of narcotics.

Canada's eventual passage of the *Opium Act* was part of an international campaign against the opium trade and reflected similar social movements in the United States and Australia. However, much of the action to control opium seemed fuelled by suspicion of Chinese men and the racist assumption that white women needed to be protected from them.

Modern Patterns of Tobacco and Drug Use

Tobacco Use

Cigarette advertisements explicitly directed at women began to appear in the late 1920s, encouraging the growing use of cigarettes by women in Canada. The social acceptability of smoking among women slowly increased during the 1930s and began to peak in the years following the Second World War. A number of social changes, which also emerged in the United States and in England, affected women's behavior in general. During the Second World War, women had been required to enter the paid labor force to replace male workers who were fighting overseas. This situation not only allowed women the chance to prove themselves capable of many types of work; it also brought into question remaining prejudices regarding women's rightful place and role. Behaviors previously considered "masculine," such as smoking, were thus more easily adopted by Canadian women.

During the war, it served the interests of industry and country for women to take on the roles of men. As well, the tobacco companies discovered a large, untapped market of women who were receptive to new tobacco products and advertising campaigns. The tobacco companies were patriotic supporters of the war effort, and often ran advertising campaigns urging those at home to show their support for overseas soldiers by sending them cartons of cigarettes. In this way, links between smoking, equality and patriotism were strengthened; these links overshadowed any remaining moral objections to cigarette smoking.

The amount of tobacco advertising directed at women continued to grow prior to widespread medical research into the health risks of tobacco use and the appearance of the first article on the subject in the 1940s (Ernster, 1985; Howe, 1984:4). By the 1950s, however, health activists had begun lobbying against tobacco use.

At first, it was believed that smoking-related diseases were male specific, but as tobacco use increased among females, so did the rates of smoking-relating diseases and deaths. Even so, until the 1980s, male smokers were the major focus of medical research into tobacco use and treatments for addiction.

Currently, rates of smoking among women are converging with those of men, since women are not reducing their rates of smoking as quickly as are men. Over the past two decades, smoking rates among males have dropped 43 per cent, while smoking rates among females have dropped only by 18 per cent. Recently, young women in Canada have begun to smoke at rates that are slightly higher than those found among their male counterparts. This trend represents a reversal of the traditional patterns of smoking and has also been found in several other developed countries. These facts may have one or more implications: the prevention and education programs of the past may not have been as effective for girls and women as they have been for boys and men; or, perhaps, women's smoking reflects recent changes to women's lives.

Drug Use

In general, illicit drug use has been a male preserve, while licit and prescribed drugs have been more often utilized by women. Several theories have been put forth to explain this pattern. One theory, for example, suggests that because of socioeconomic differences between men and women, men have more disposable income, which they can spend on drugs. Another theory

is based on the notion of "cultural diffusion." This theory suggests that new ideas and behaviors – including the taking of drugs – spread first among males in cultures where men are dominant. Such ideas and behaviors will, the theory suggests, spread later to women (Ferrence & Whitehead, 1980, Chapter 4).

Women's rate of consumption of licit psychotropic drugs is, however, about twice that of men (Cooperstock, 1983). It has been argued that their use of licit drugs is dependent upon their access to prescribing agents, health care, information and advertising. Women have been found to visit doctors more frequently than men, to express more help-seeking behaviors, and to exhibit more dependencies and more neuroses. Some researchers believe that women may be more biologically, psychologically or socially susceptible than are men to disturbances needing drugs (Pihl, Marinier, Lapp & Drake, 1982).

It has been noted, on the other hand, that doctors (particularly during the 1960s and 1970s) have often stereotyped women patients. The stereotypes have reflected images found in drug company advertisements and anti-woman attitudes taught at medical school. Doctors' stereotypical beliefs regarding women have led them to prescribe more psychoactive drugs to their female patients than to their male patients (Pihl et al., 1982). Seidenberg (1971) noted that drug companies have promoted the idea that women need psychoactive drugs to "cope," and that after taking them they will quit "bothering" their physicians. This medicalization of women's problems means it was believed that women's symptoms needed medical interventions or drug therapy. Members of medical and therapeutic communities have rarely considered the idea that women's symptoms may be a response to social or economic issues or conditions. (For a more in-depth discussion of medicalization, see Chapter 2.)

With the rise in activity of the current women's movement in general, and the women's health movement in particular, doctors' practices have come under greater scrutiny. A consumer-oriented critical appraisal of how medical professionals and those working in social institutions regard women has replaced the idea that women were to be objects of professional attention and manipulation.

While illicit drug use is still more of a male than female activity, studies regarding the use of recreational drugs (e.g., marijuana) during the period from 1965 to 1980 did include responses from females. Similarly, while most modern illicit drug users are middle class and from dominant racial and ethnic groups, there are exceptions among the Canadian population. The use of inhalants, for example, is particularly widespread among native youth.

Modern Reactions to Tobacco and Drug Use

The anti-smoking movement of the last few decades has put forth a message that is primarily pro-health. More recently, in reaction to research findings on the hazards of environmental tobacco smoke, it has also put forth a non-smoker's rights message. Because the ill effects of smoking became apparent in men before they became apparent in women, the first campaigns for smoking prevention and cessation and treatment measures were directed at men.

It was only in the 1970s that anti-smoking messages and treatment programs were directed at and designed for women (Jacobson, 1981). Campaigns publicized the risks associated with smoking and pregnancy, and the possibility of

acquiring facial wrinkles from smoking. These campaigns are now regarded as sexist in their approach. They did not promote women's health for its own sake, but emphasized how tobacco use could restrict women from fulfilling their roles as reproducers and "sex objects." While the campaign against smoking during pregnancy did, and still does, have considerable merit with regard to women's health, the same cannot be said for the facial wrinkles campaign.

There is a striking similarity between the early responses to women's tobacco use, social responses to women's alcohol use during the last century, and the reaction to women's use of mind-altering substances in recent times. In all cases, women's substance abuse has been viewed as threatening because it weakens their abilities to function as responsible reproducers and mothers. Even though the effects of tobacco smoke on a fetus or child are perhaps less immediately dramatic and obvious than the effects of excessive drinking or drug taking, initial health promotion campaigns aimed at women smokers focused on these effects. The modern facial wrinkles campaign can be seen to reflect the nineteenth-century notion that substance abuse is unfeminine, improper or unladylike.

Only in the 1980s did the objectification of women begin to be challenged in tobacco treatment and education programs. Due to a strengthened women's movement and a more feminist approach to both health care and addictions treatment, other substance abuse prevention, education and treatment programs are also being challenged and improved. Many modern programs are supposed to be gender neutral (i.e., not specifically aimed at either men or women); most, however, remain more male oriented in their approach. As well, some practitioners argue that the expenditure of treatment dollars is determined more by men's drug use patterns and problems than by those of women (Dammann & Soler, 1979:5).

The contemporary response to female smokers in Canada, and in several other developed countries, avoids "victim-blaming," favoring a more sensitive, holistic model for both prevention and treatment. There are several efforts underway to develop both prevention tools and treatment programs that deal with the general social and psychological issues assumed to underpin the need to smoke among women and girls (Greaves, 1991). In addition, there is an increased attempt to understand the impact and meaning of smoking among women and girls in modern times (Greaves, 1990b). Despite the obvious and indisputable links between poor health and smoking, a substantial proportion of Canadians still smoke, and teenage girls are now taking up smoking at a higher rate than are teenage boys.

Conclusion

A historical review of women's reactions to and consumption of alcohol, tobacco and other drugs in Canada is not complete without a comparison of the effects of these substances on women, in contrast to their effects on men, and of how the differences in these effects influence women's roles. Alcohol and other mind-altering drugs (such as opiates and hallucinogens) are substances with detectable effects – substances that can potentially interfere with people's ability to carry out their responsibilities. Within this context, it makes sense when society is critical of women's abuse of these substances. It especially makes sense when that society's stability may depend upon

women soberly and responsibly carrying out their roles as wives and mothers. With the rise of industrialization and capitalism in Canada in the nineteenth century – when the sex role division of labor became pronounced, particularly in middle-class homes – the development of morally based disapproving attitudes to women's substance abuse became rooted.

It must also be noted, however, that the consumption of tobacco and certain other drugs (such as cocaine and psychotropic drugs) does not necessarily render a woman incapable of carrying out her duties. In fact, it can be argued that tobacco smoking – when used to reduce stress, calm negative emotions or dampen appetite – may facilitate expected female behaviors. For example, when women are smoking, instead of expressing negative emotions or discontent, they are compliant, and the status quo is temporarily maintained.

The use of cocaine may also enable women to fulfil socially expected roles. A woman's cocaine use is often largely invisible, at least at first, and can make her efficient, productive, sexual and thin.

> *[C]ocaine addicts, unlike other substance abusers, are highly "functional," at least initially. Plus, their drug use doesn't produce the obvious signs of intoxication associated with alcohol, marijuana, opiates, or other drugs.*
>
> *(Greenleaf, 1989:17)*

In the case of illicit drugs, the substance abuse begins to interfere with the carrying out of role expectations only when the high cost of maintaining the addiction has become a burden. Nevertheless, women involved with illegal drugs are seriously stigmatized, and their drug use is perceived to be linked to immorality, prostitution and poor mothering.

> *Considering, on the one hand, the punitive, rejecting attitude toward women addicts, and the kinder, more accepting attitude toward the female user (and abuser) of medication, the outcome is predictable.*
>
> *(Gomberg, 1982:15)*

In contrast, the use and abuse of tobacco and prescription psychotropic drugs, which are legal and relatively low priced, remains high among women. Cessation efforts can be costly and difficult for women; without considerable support, such efforts can cause increased strain on relationships or life situations. Smoking and some drug taking are clearly no longer explicitly encouraged. However, implicit social support remains – and will remain, as long as women's inequality in society stays unaddressed.

Implications for Prevention and Treatment

If pressures on women continue to increase, but solutions for the relief of pressures remain unavailable, women and girls will likely continue to internalize their problems. Some researchers believe that women are more likely than men to internalize and less likely to act out anger or other negative emotions. Hence, women may be more susceptible to substance abuse. This does not necessarily mean that women will abuse alcohol, tobacco or other drugs in larger quantities or at higher rates than men do. It does suggest, however, that the motivation for their consumption may differ from that of men.

It is reasonable that some researchers have begun to question the utility of prevention and substance abuse

treatment programs that are identical for men and women. Not only do women have different structural needs than men when entering treatment (e.g., day care, transportation, cost subsidies), they may also have different therapeutic needs (e.g., more sharing of ideas, social support, empowering treatment messages, building of self-esteem) (Greaves, 1990a).

Along the same lines, philosophical questions about the types of treatments offered have been raised. There is growing criticism of traditional addictions treatment programs, which often demand that one "surrender" either to a higher power or to a healing process (as is done in the Alcoholics Anonymous movement, for example). Feminist critiques of drug and alcohol treatment stress the need for programs that encourage the empowerment of women and increase assertiveness and self-esteem (as is done in the Women for Sobriety movement, for instance), and the dismantling of those that serve to increase women's humility, compliance and self-doubt. As the link between women's substance abuse and women's social inequality is uncovered and made public, increased demands are also being made for prevention and treatment programs that explicitly address this link.

Sexism, in society and in medical practice, has fostered passivity in women and demeaning attitudes in medical practitioners toward women. This has allowed women to "unwittingly fall into drug dependence due to doctors' attempts to 'help' women adjust through drugs to an uncomfortable sex-typed role" (Halas, 1979:14).

Fortunately, a woman-centred perspective is now emerging in the addictions field, in Canada and elsewhere. Fuelled by the strengthened consumer and women's movements of the late twentieth century, dedicated professionals are demanding a different approach to treating all forms of substance abuse among women.

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CHAPTER 2

The Historical Context of Medicalization and Gender: Its Relationship to Alcohol and Other Drug Use in Canada

Juanne Clarke

Women and men today differ in terms of their substance use. This chapter will focus on the substance use behavior of the recent past and, particularly, on the impact of medicalization (defined below) on gender and drug use.

Currently, women drink less than men and suffer fewer alcohol-related difficulties. They are treated less often for alcohol-related problems, and their mortality rate from alcohol dependency is below that of men. On the other hand, women use a greater number of prescription medications than men. They are particularly more likely to use prescribed psychoactive substances. They are more frequently ill by whatever measure is used, including self-reports, clinical evaluation, days of disability, bed days, hospitalization records and the like (Clarke, 1983). They are more likely to visit the doctor for their own illnesses, pregnancy and childbirth, as well as for the health of their children. Women's experiences and, to a lesser degree, those of men, have been altered by the medicalization process – that is, the defining of aspects of everyday experience as medical issues. The trend toward medicalization has had a direct impact on the control that women exercise over their bodies and their lives.

The Late Nineteenth and Twentieth Centuries

A number of social commentators have noted that the late nineteenth and twentieth centuries can be characterized by a trend toward increasing medicalization. Medicalization is best seen as a historical process. From the beginning of the nine-

teenth century, allopathic (Western medical) doctors (who have mostly been white males) have been viewed, by themselves and society generally, as *the* legitimate, scientifically trained medical practitioners. In doing so, they have attempted to consolidate their power – often over female homeopathic healers and midwives – to diagnose and treat in the areas they considered related to health (Ehrenreich & English, 1973). As their power and their social acceptance grew with respect to narrowly defined health-related matters, their interest also grew in defining as medical other, formerly social matters (e.g., childbirth and alcoholism). These two processes – the increasing power of the medical profession and the subsequent growth of its control in areas formerly outside the arena of medicine – are two aspects of medicalization.

Several authors have written about medicalization in a variety of contexts (e.g., Clarke, 1979, 1984, in press; Conrad, 1979; Conrad & Schneider, 1980; Doyal, 1979; Eisen, 1983; Imershein, 1977; Pill, 1987; Riessman, 1983), and there seems to be some agreement regarding its definition: medicalization is the understanding of human social relations according to a rather narrow medical paradigm or model. For example, normal social relations are often referred to as "healthy," and abnormal social relations are described as "sick" (Clarke, 1979). Conrad and Schneider (1980) point out that medicalization can be seen at the conceptual level (e.g., the use of medical terms to define a problem), at the individual level (e.g., within the doctor–patient relationship) and at the institutional level (e.g., between the medical system and the patients).

Medicalization is the result of concrete actions taken by medical practitioners to establish their power (Imershein, 1977; Illich, 1982), their increasing economic and social organization (Doyal, 1979) and the growing effectiveness of early scientific discovery. It is also the result of technological advancements, as well as the growth of the bureaucracy of hospital and other medical services, including the drug industry (Clarke, 1979). Pill (1987), in her discussion of patients' and doctors' views of cystitis in women, alludes to the role that the lay public has played in promoting medicalization. The author points out that, after contact with doctors, patients readily tended to accept and reinforce medical theories of infection. They lost confidence in the importance of basic preventive and treatment measures. Riessman (1983) has noted how, in the past century, upper-class women contributed to medicalization by utilizing medical treatments. As a result of their desire to be free from pain and to be seen as delicate (which was thought to indicate refinement and good breeding), women of the upper class increasingly went to doctors. This trend later filtered down to other social classes.

The emergence of medicine as a means of social control is another aspect of medicalization (e.g., Clarke, 1984; Conrad, 1979; Conrad & Schneider, 1980). As more problems are defined in medical terms, the opportunities increase for medicine to provide the only solutions to those problems. This power to define reality constitutes a significant component of social control. For example, when deviance is defined in medical terms, medical institutions and practitioners adopt the role of agents for social control by providing psychiatric services, drugs and so on (Conrad, 1979). Medicalization has affected women differently than men. Historically, medical professionals have viewed women's ailments and complaints as being primarily biological in nature and men's problems as being intellectual lapses

(e.g., CMHA, 1987; Ehrenreich & English, 1978; Eisen, 1983; Riessman, 1983). A popular belief among medical practitioners of the nineteenth century was that each individual possessed a limited amount of energy to expend throughout his or her lifetime. For women, whose main function in life was believed to be reproduction, the results of this "energy" theory were indeed serious. Women were advised against doing *anything* that might waste energy meant to be used for reproduction (Corea, 1985; Ehrenreich & English, 1978). Related to these thoughts about women's energy, and what it was to be used for, was the belief that women's reproductive organs ruled every facet of women's lives – their intellect, their emotions, their very "being" (Mitchinson, 1987). Because of their reproductive capacities, women were viewed not only as being different from men, but as being defective (e.g., Corea, 1985; Ehrenreich & English, 1978; Mitchinson, 1987). The male body was the prototype and the female body was compared to it: men were standard and women were abnormal.

When one considers doctors' assumptions that women's bodies were inherently inferior, it is not surprising that, as Corea (1985) and Ehrenreich and English (1978) have pointed out, women were viewed as naturally sickly. Women were expected to be unhealthy, as that was considered a sign of femininity, wealth and good breeding. This state of sickness was believed by medical professionals to be caused by women's "femaleness." The presence of the reproductive organs, menstruation, pregnancy and menopause were believed to incapacitate women, keeping them from participating in activities, such as education and employment.

The establishment and growth of gynecology as an area of medical specialization show the extent to which women's bodies have become increasingly medicalized (Ehrenreich & English, 1978). Gynecology focuses completely upon the female reproductive system. Women's life cycles have been redefined as medical crises that women must overcome with the expert assistance of medical professionals. Menstruation, pregnancy, childbirth, menopause – all these normal, healthy events in a woman's life – were and to an extent still are viewed by medical practitioners as (potentially) disabling illnesses requiring medical treatment. Even a woman's enjoyment of her own sexual capacity was at one time considered pathological or "diseased." Masturbation was described by doctors as the cause of uterine cancer and vaginal infections (Corea, 1985). More harmful than these beliefs were some of the interventions designed by doctors to "treat" female abnormalities – clitoridectomies, ovariectomies and hysterectomies (e.g., Corea, 1985; Ehrenreich & English, 1978; Eisen, 1983). Ehrenreich and English (1978) note that the male reproductive system has not been similarly pathologized. In fact, there is no male equivalent to gynecology.

In addition to treating normal, physical changes in women's lives as pathological, doctors have often dismissed women's legitimate physical complaints as nothing more than evidence of their "hysteria" or naturally weaker psychological makeup. Menstrual cramps and labor pains sometimes became proof of psychosomatic illness. If a woman complained of pain during menstruation, the problem was "all in her head" and could be "cured" with counselling, psychiatric treatment and psychotropic drugs (e.g., Ehrenreich & English, 1978; Eisen, 1983). Cogswell and Arndt (1980) and Doyal (1979) state that medical professionals still continue to underdiagnose, that is, dismiss genuine disorders as being

psychosomatic, or to hold that women inaccurately report their symptoms. Consequently, medical professionals continue to prescribe mood-altering drugs.

Doctors also tend to retain negative stereotypes about normal and abnormal behavior for women (Cogswell & Arndt, 1980). Doctors often expect and perceive women to be more emotional than men, which in part contributes to doctors' prescribing more minor tranquillizers to women than to men (Gabe & Calnan, 1989). Advertising that is sent to doctors by drug manufacturers reinforces negative stereotypes about women and about "normal" gender role characteristics (Rochon-Ford, 1986). In her research on the depiction of women in pharmaceutical advertisements, Rochon-Ford found that five predominant themes consistently emerged: (1) women cannot cope, (2) doctors know best, (3) women are dumb, (4) a woman's biology is her destiny and (5) women are a homogeneous group. The overarching message of the advertisements was that women should be medically "managed" with mood-altering drugs. Not surprisingly, Gabe and Calnan (1989) note that the majority of drug advertisements depicting women promote drugs for psychogenic disorders. Women are usually shown as requiring psychoactive drugs to treat anxiety, tension and depression, whereas men are shown as needing drugs for work-related difficulties or disabilities (Cogswell & Arndt, 1980).

Also contributing to the different effects of medicalization upon women and men is the fact that doctors are trained in an environment dominated by male values and perspectives, which reflects male-centred views of "normal" female behavior. In medical schools, women patients are sometimes depicted as presenting with psychosomatic illnesses that are not very interesting, and that women are not able to describe symptoms comprehensively to their doctors (e.g., CMHA, 1987; Cogswell & Arndt, 1980). Behaviors seen as normal for men are frequently thought by doctors to be a sign of pathology when exhibited by women. As well, women's behaviors are often labelled in demeaning, low-status terms. For example, women's abilities to meet others' needs instead of their own is often referred to as "masochism" (CMHA, 1987). Because most medical and mental health professionals are men, who receive very little exposure to women's concerns in medical schools, the importance of the social causes of women's health problems is neglected. This reinforces the medical model's focus on internal and psychological causal factors of illness (e.g., CMHA, 1987; Riessman, 1983). Medical professionals have consistently pathologized women's experiences. For example, the treatment of pregnancy and childbirth as pathological medical events has often led to the sacrifice of women's needs and rights for respect in order to use active medical treatments and interventions (e.g., CMHA, 1987; Cogswell & Arndt, 1980). In general, because women use medical services more than men, they are more likely to be subject to interventions using medical technology, including prescription and over-the-counter drugs.

Medicalization, Drugs and Alcohol

Medicalization contributed to and flourished as a result of the increasing availability and use of drugs to deal with human social problems. Psychotropic or psychoactive drugs, which affect one's thinking, mood and/or behaviors, are most commonly discussed in the literature. These can be divided into six broad categories: (1) narcotics (e.g., opiates, which include opium, as well as any drug

with properties similar to opium or its main ingredient, morphine), (2) sedatives (e.g., alcohol, barbiturates), (3) stimulants (e.g., amphetamines, cocaine), (4) psychedelics and hallucinogens (e.g., cannabis, peyote, psilocybin, LSD, PCP), (5) anti-anxiety drugs or tranquillizers (e.g., benzodiazepines such as Librium and Valium) and (6) antipsychotic drugs or neuroleptics (e.g., Thorazine, Haldol).

Alcohol is a commonly used sedative in North America. Its abuse is viewed as more or less acceptable depending upon the gender of the abuser. Medical and mental health professionals are likely to see women who abuse alcohol as being far sicker and more pathological than men (e.g., Badiet, 1976; Erickson & Murray, 1989; Fraser, 1976; Ross, Glaser & Stiasny, 1988). Such discrimination is firmly rooted in the historical tendency of medical professionals to place very narrow limits on appropriate sex role behaviors for men and women. Ross, Glaser and Stiasny (1988) have suggested that, because excessive consumption of alcohol is regarded as male behavior, women who drink heavily are seen as abnormal or as acting inappropriately. Erickson and Murray (1989) point out that women who abuse alcohol are frequently perceived as being sexually corrupted and as abandoning their most profound responsibilities as care providers and nurturers. It seems that the double standard described earlier is operating today; whether it has moderated or not needs to be determined through research.

Several authors have noted that women are more likely than men to receive prescriptions for and to use psychotropic drugs (e.g., CMHA, 1987; Cooperstock & Lennard, 1987; Cooperstock & Parnell, 1982; D'Arcy & Siddique, 1985; Kaufert & Gilbert, 1986; Ross, Glaser & Stiasny, 1988). The 1987 Canadian Mental Health Association (CMHA) report indicated that, in Canada, 67 per cent to 72 per cent of all psychotropic drugs are prescribed to women; most of these medications are addictive tranquillizers, such as Valium. D'Arcy and Siddique (1985) have noted that women also significantly exceed men in their use of non-prescription or over-the-counter drugs, such as painkillers.

Conclusion

The overprescription of psychotropic drugs to women by medical professionals can be seen as the result of many factors, some of which have been suggested previously in the discussion of the unique implications of medicalization for women. Physicians tend to hold a biological view of depression, and thus tend to treat it primarily as a physical condition. Because women report suffering from depression more than men do, women are more likely to be prescribed mood-altering medications (e.g., CMHA, 1987; Cogswell & Arndt, 1980). Another factor contributing to the overprescription of psychotropic drugs to women is the stereotyped view of women held by physicians and reinforced by drug advertising (Badiet, 1976).[1] Cooperstock (1971) states that doctors accept the stereotype of women as being more expressive and emotional than men and, consequently, they expect their female clients to express their feelings and complaints and to *require* mood-altering drugs more often than their male clients. Women get prescriptions for psychotropic drugs from their physicians (Badiet, 1976). Physicians in a medicalized culture legitimize the overprescription and overuse of psychotropic drugs by women (Erickson & Murray, 1989).

However, women are caught in a double bind with respect to psychotropic medications. While the use of psy-

chotropic drugs by women is accepted and even promoted, women's abuse of drugs draws a much more negative and condemning reaction than does men's abuse of drugs (Erickson & Murray, 1989). As with women's abuse of alcohol, their misuse of drugs is generally viewed as being far more pathological than substance abuse by men. Drug abuse by women is viewed as a sign of sexual depravity, and an offensive departure from the "proper" female role.

Notes

1. Ross et al. disputed this stereotype of the female substance abuser in their 1988 study, when they explored the prevalence of mental disorders in men and women who sought treatment for substance abuse in Toronto. The researchers found that, while more women than men received prescriptions for and were using psychotropic drugs, they were no more likely than men to have psychiatric diagnoses in addition to their substance abuse problems, thereby suggesting that substance-abusing women are no more pathological than their male counterparts.

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CHAPTER 3

Canadian Women and the Temperance Movement: A Historical Perspective[1]

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The story of alcohol and its abuse has traditionally been written in the masculine gender. One may remember the dramatic orgy described in *The Bacchae*, the Greek classic by Euripides. During its course, Agaue, in a state of Dionysiac drunkenness, kills her own son, Pentheus. This episode, featuring a drunken woman as a lead character, is exceptional in Western literature. It may, however, reveal a hidden truth about alcoholism: that women have very likely always drunk alcohol, some to the point of severe intoxication.

The first substantive piece of writing on alcoholism, Seneca's *Epistle LXXXIII: On Drunkenness* (Seneque, 1942 ed.), was written with men in mind, and it appears that the famous stoic set the tone for future works on the subject. In *A History of Alcoholism*, Sournia (1986) relates situations exclusively involving men, with the exception of the Gin Epidemic which took place in England during the first part of the eighteenth century. Women have been absent from several major studies that have had an impact in the field of alcohol addiction in the last 15 years: the study comparing "treatment" and "advice" at the Maudsley Hospital (Edwards et al, 1977), the Rand Report on the evaluation of treatment (Armor, Polich & Stambul, 1978; Polich, Armor & Braiker, 1981) and Vaillant's (1983) longitudinal study on the natural history of alcoholism.

The epidemiological data may partially explain the absence of women: in comparison to men, women drink less alcohol and consume it less frequently. Alcohol abuse, alcohol-related problems and alcohol dependency constitute primarily a male problem. Furthermore,

women seek treatment in fewer numbers than do men: the ratio is 3:1 to 5:1, depending on the mode of treatment and the geographical area in which it is offered. The mortality rate for alcohol dependency is also considerably lower for women than for men (Adrian, Jull & Williams, 1989). The 6:1 mortality ratio has not changed in the last 50 years (Adrian et al., 1989; Ferrence, 1980; Fillmore, 1984). Alcohol has been, and still is, the substance of choice for men.

This chapter seeks to discover whether or not this gender division in the patterns of consumption by men and women finds its origin in the nineteenth century. It focuses on the temperance movement, since it was this social movement that exercised the most influence on ideas about alcohol at that time. More specifically, this chapter seeks to determine whether the temperance movement shaped the definition of drunkenness as a predominantly male problem and female drunkenness as a form of moral degradation.

The Approach

The authors have been limited by the existing Canadian literature. The temperance movement has left a rich legacy: manifestos, pamphlets, posters, post cards, etchings, proceedings of meetings and conferences. The sources of information are numerous. Sources from the history of medicine and medical discourse are also numerous and have been studied at length. However, in trying to examine the consumption patterns of women – if they drank, how much and with whom, where and when their drinking occurred – it became evident that many sources constitute a prescriptive anti-drinking discourse, which reveals little about actual practices of the time. Thus, it is not possible to ascertain whether the prevalence of alcohol-related problems in nineteenth-century Canada justified the call for temperance, abstinence and Prohibition. As reliable data are simply not available, we will therefore limit ourselves to examining how this discourse shaped attitudes.

There certainly was drunkenness and it was, as it is today, a significant problem that caused many personal and social ills. However, the absence of information regarding female behavior presents a major difficulty in this study (as it does in other areas of historical research, where questions about women have never been central). Historical discussions surround women, but never focus directly upon them. Reflecting upon the limits of present knowledge, the authors came to the conclusion that there is a great need for a feminist study of past female consumption patterns.

The Pre-Temperance Period: 1785 to 1827

Very few historians have studied Canadian drinking patterns prior to the temperance movement, which commenced in Canada at the end of the 1820s. Authors who have studied the subject agree that heavy drinking was common at the time for all ages, classes, and for both sexes. In Canada, the lack of data does not permit reliable estimates of the quantity of alcohol that was consumed prior to the temperance movement. In both Upper and Lower Canada, inferences concerning consumption patterns are made from the number of distilleries and taverns that were in operation. Public drinking places were numerous in Ontario and in Quebec. In 1833, for example, from Hamilton to York (Toronto), over a distance of approximately 64 kilometres, there were 20 taverns (Garland & Talman, 1974). In addition, homemade wine, cider

and beer were produced and consumed in the home, constituting, no doubt, a substantial part of the per capita consumption.

Nineteenth-century travellers in Ontario have provided accounts of cases of severe intoxication, which suggests that men of position and influence, such as magistrates or staff officers, were often not sober enough to conduct their duties. Pioneers also drank excessively. When relatives and neighbors got together for work bees, the host compensated volunteers for their time with alcohol. Workers were paid with spirits. In New Brunswick in the 1830s, "an employer who did not provide rum found it hard to obtain labourers."[2] The same was true in Montreal and most probably in other parts of Canada. Public drinking places combined many functions with the simple opportunity to drink. Inns and taverns were used for official assemblies, dances, banquets, elections and religious services. Having a drink provided the perfect opportunity to exchange news, seek advice or discuss politics. People also drank at social gatherings, at weddings and at wakes. Drinking to excess was common. Alcohol abuse was also linked to premature death.

Female Drinking Patterns

It is difficult to evaluate from the available sources the drinking habits of Canadian women prior to 1840. Very little is known. Garland & Talman (1974), for example, in their research on the use of alcohol in Ontario in that period, refer essentially to men's behavior and say nothing concerning the women who lived among men and who most certainly produced alcohol and sold it to them. Women are absent from drinking stories just as they are from other areas of history. Evidence of a possible double standard concerning female intoxication is virtually non-existent. The authors consulted do not mention whether a greater stigma was attached to female drunkenness. Were intoxicated women seen as less respectable than their male counterparts?[3]

The Temperance Movement

At the turn of the nineteenth century, elite citizens of Canada and the United States became preoccupied with the issue of temperance. The phenomenon was not unique to North America: concerns about the alcohol problem developed in Western Europe as well. The temperance movement became extremely influential in the United Kingdom and the Scandinavian countries (but had less impact in wine-growing countries) (Barrows & Room, 1991). In fact, the temperance movement became the most influential social and political force of the last century. It thus cannot be understood from a feminist perspective without some comprehension of the changes in gender roles that took place as a result of the industrial revolution: the major social and economic upheaval that transformed life for a large number of people in the nineteenth century.

The Industrial Revolution

Before the industrial revolution, all family members contributed to home-based economies as the means of guaranteeing their physical survival (Cohen, 1988; Gattfield, 1979; Ryan, 1981). The husband was in charge of all economic relations, and of the training and supervision of children, while the wife acted as household manager, producing the food and clothing for home consumption. With the introduction of factories, which paid wages to individuals and not to families,

this system of production began to erode, and with it some of the relationships it generated. In Canada, these changes became visible around the mid-1800s.

Social class helped to determine how people experienced these transformations. In most middle-class families, professional pursuits took men outside the home, leaving women behind as household managers and full-time child minders. The intensification of the mother–child bond raised the status of motherhood to almost mythic proportions. Blocked in their access to paid work, married women's prestige and authority arose from their maternal and housekeeping roles. American women's historians (Cott, 1977; Smith-Rosenberg, 1985; Welter, 1976) have referred to this phenomenon, which took place in the last third of the century, as "The Cult of True Womanhood." Womanhood came to stand for all that was missing in men's "economic" world (Smith-Rosenberg, 1985; Welter, 1976). Furthermore, it became acknowledged that women's superiority was not founded upon ability or power, for those were male attributes, but upon their more developed moral sense, which was attributed to maternal instinct.

On the other hand, working-class families lived in social, physical and economic worlds that were substantially different. Wives of workers were not isolated in the home to the same degree as were women of the middle class. The material realities of poverty continually pushed women and children outside the home in search of the means of survival. The fate of women, children and men was firmly bound up in a family economy to which all members contributed (Bradbury, 1979; Stansell, 1986). The middle-class ideal of separate spheres held little meaning for working-class families, whose members lived much of their lives outside their homes in search of work and pleasure.

In addition, urbanization and immigration had a significant impact throughout this period, particularly in Toronto and Montreal. By the 1850s, the native born and the immigrant, many of whom were Irish escaping the potato famines, gravitated toward the cities in search of work. Most were poor, and, in the case of the Irish, their traditions and long history of conflict with the English inspired anxiety among the Anglo-Saxons beside whom they settled. Furthermore, every successive wave of non-British immigration served to heighten the fear of the foreigner in the minds of some Canadians of more prosperous means.

Migration was not limited to the cities. Between 1851 and 1891, young men flocked to the Prairies, the Northwest Territories and the United States in search of greater economic opportunities (Prentice, Bourne, et al., 1988). Women were also on the move, but in the direction of the large urban centres, where employment for females was most readily available. These shifts in population tipped the gender balance in the favor of women in the big eastern cities, where they outnumbered men of marriageable age (Cross, 1977). This shift gave rise to the disturbing image of the single working woman, independent of family ties and responsibilities. The idea, if not the reality, of the single working woman implicitly challenged a society organized along sharp gender divisions (Stansell, 1986).

In the city, the social problems of intemperance, poverty, crime and sickness were magnified. Poverty took on a whole new dimension. City densities brought the hardships of the poor into proximity with the comforts of the middle class. Some members of the middle class became horrified by the newly visible

signs of poverty. The state of being poor was no longer associated with the will of God, but with an inability to compete successfully in the marketplace. Moral failings of the poor (looseness with money and sex; drunkenness and gambling), which had drawn only minor social commentary in the eighteenth century, became the major focus of moral reformers in the nineteenth century (Stansell, 1986). The misery of the working poor could be relieved if only they would adopt as their own the middle-class values of hard work, thrift, soberness and sexual restraint. Consequently, the role of charity was to encourage the rehabilitation of the "deserving" poor, those who expressed sufficient will to give up their "idle ways."

The Temperance Movement from 1827 to 1874

It was at the dawn of these profound social changes that citizens preoccupied with temperance organized themselves. The first groups were formed in New England and in Virginia (Bernard, 1991; Garland & Talman, 1974). The landmark date is 1826, when the American Temperance Society was founded. The Presbyterian and the Methodist clergy initiated the first temperance societies[4] in conjunction with men of the elite. The movement swept the Republic very rapidly: by 1833, there were 6,000 temperance societies in the United States (Voisine, 1979), and the movement "grew from an elite cause to a mass movement of a broad section of an American middle class" (Levine, 1984:111).

The Canadian Scene

According to the Royal Commission on Liquor Traffic, held in Canada from 1892–94, the first organized temperance society met in West River, Pictou County, Nova Scotia, in 1827 (Royal Commission on Liquor Traffic, 1895). In Montreal, the Saint Andrew Presbyterian Church hosted that city's first temperance meeting, on the evening of June 9, 1828. A similar meeting took place the same year in Quebec City (Blais-Hildebrand, 1975). In Upper Canada, the first temperance society was founded in Bastard Township, in Leeds County, on June 10, 1828. By 1829, there were societies in Beverly, Ancaster and Stoney Creek. By 1832, 100 societies were reported to be in existence (Garland & Talman, 1974). In Quebec, the first French-speaking society, *l'Association catholique de Beauport*, was founded in 1840 (Voisine, 1979).

British and American influences shaped the development of the temperance movement in all parts of Canada (Barron, 1980). In West River, Pictou County, Nova Scotia, for example, the presence of the Halifax Naval Base stimulated close community links with England. Elsewhere, the Presbyterian, Methodist, Episcopal, and many sections of the Baptist church depended on the United States for their leaders (Chapman, 1954). Moreover, in certain areas of Canada there were significant commercial ties with the United States. It is clear that from 1849 to 1852, Maine and New Brunswick co-operated on such projects as the European and North American Railway. This collaboration led to considerable influence being exercised by the Maine temperance movement on New Brunswick (Chapman, 1954).

It is also important to evaluate the impact of the large-scale immigration of United Empire Loyalists to Ontario, Quebec and the Maritimes after the Declaration of Independence. In Montreal, the Canadian mecca of temperance, written material was frequently imported

from England, and the tactics used also showed the marked influence of the mother country. The written material and the strategies were then exported to Ontario, where the crusade started a little later (Barron, 1980).

The First Temperance Wave: 1827 to 1855

Temperance societies, in the first 25 years of their existence, were not anti-alcohol. They advocated abstention from distilled spirits but found acceptable the consumption of fermented beverages: beer, wine or cider. Furthermore, while the festive or convivial use of distilled spirits was condemned, the use of spirits as medicine was still considered legitimate. During the cholera epidemic of 1838 in Montreal, the temperance campaign, begun a decade earlier, was severely undermined by the popularly held belief in spirits as the most effective cure. As a medicine, alcohol remained the "Good Creature of God," an idea that had common currency in the eighteenth century.

Despite this, the Canadian temperance societies still saw alcohol as a dangerous drug. It was perceived to be powerfully addictive: once the pathological process of addiction was established, the desire for alcohol was viewed to be uncontrollable. Furthermore, the "poison alcohol" was held to weaken the body, making it vulnerable to multiple diseases. The substance also had harmful effects on the user's behavior and destroyed all inhibitions, leaving the drunken man naturally violent. The Quebec clergy outlined their position in the following statement: *"L'alcool rend l'homme semblable à la bête et souvent le fait mourir"* ("Alcohol makes a beast out of a man and often kills him"). Because of its evil properties, the substance was perceived to be the cause of all social problems.[5]

Female Drinking Patterns

Membership in the first temperance societies was made up exclusively of men. Blais-Hildebrand (1975), in her study of the first temperance societies in Montreal dating from 1828, found that most members came from the city's social elite: bankers, wealthy businessmen, merchants. Studies indicate that the membership of other temperance societies in other parts of the country and in the United States (Bernard, 1991) had a similar composition. This bourgeois elite had a vested interest in shaping a society in which the working class would labor diligently.

When the call for temperance mobilized the masses and became a popular crusade,[6] women of both Upper and Lower Canada joined the movement. In French Canada, where the first waves of Catholic temperance began in 1840, women formed the majority of those who came to hear the passionate sermons of Monseigneur de Forbin-Janson and Charles Chiniquy, the vicar of Beaupré. Having heard the "good word," many had conversion experiences (Chiniquy, 1847; Hardy, 1968; Voisine, 1971, 1979). The temperance movement gave rise to a wealth of newspapers, pamphlets, etchings, conferences, meetings, theatre performances and parades promoting the "cause." Whether women took part in the production of this propaganda remains to be uncovered.

Evidence from this period, as from the pre-temperance era, suggests the presence of female drunkenness. From January to November 1846, Montreal police arrested 315 (20 per cent) women and 1,273 men in a state of drunkenness. During the same period, 146 women (15 per cent) and 792 men were arrested for having caused scandal and troubling the peace when intoxicated (Chiniquy, 1847). It is not possible to know how

representative this figure is for the total population, since one individual may have been arrested many times, thus distorting the overall percentage.

Evidence also suggests the existence of a double standard regarding female intoxication. In the *Manuel des sociétés de tempérance*, the manifesto of the French Canadian temperance movement, the author, Reverend Charles Chiniquy (1847), presents 12 cases of alcohol-related death, taken from the archives of the Quebec City coroner. Three of these cases, outlined as cautionary tales, involve women: one features the daughter of a well-to-do family, who started out drinking at adolescence, ended up in a brothel (where else?), and died of her wounds following a fight with three other women; a second features Marie, a farmer's wife and mother, who froze to death because she was drunk; finally, Chiniquy writes of Émilie, an alcoholic, to whom her husband, exasperated by her drinking, gave as much alcohol as she wanted – resulting in her death from drunkenness within two weeks. Presenting a fourth story, Chiniquy recounts the tale of an alcoholic woman who, in a state of complete intoxication, fell on her child and choked him to death. He concludes that in Ancient Rome, women who enjoyed too much wine were punished by death, adding that the Romans behaved wisely. In Chiniquy's other tales, men also died of intoxication or were involved in fatal accidents while intoxicated. Both sexes are represented as being irresponsible and degenerate human beings.

In other parts of the *Manuel des sociétés de tempérance*, Chiniquy (1847) presents stories of alcoholic women who exhibited less physical resistance to alcohol than their male counterparts and, as a result, their death came more rapidly. The author, however, does not infer more wickedness or degradation on the part of the female sex. Even if women drinkers are described as bad mothers or as "fallen women," their failures are not central to their case histories. It is their rapid death, followed by damnation, that is key to the narrative – punishment and vengeance being the author's main obsessions. In fact, Chiniquy's discourse was extremely violent even by the standards of his time, and as a result he was severely reprimanded by his bishop for inciting violence toward alcohol merchants (Trudel, 1954). Nevertheless, while the stigmatization of female intoxication is not blatant in this book, this does not rule out the possibility of its presence in French Canadian society at the time, as well as in the English-speaking community of the rest of Canada.

The Washingtonian Total Abstinence Movement

In 1840, the Washingtonian Total Abstinence Movement was created in Baltimore. It consisted of a group of working-class drunkards whose aim was to help men like themselves become sober (Blumberg, 1977; Maxwell, 1950). Soon after, in 1841, a Montreal chapter of the Washingtonians, the Victoria Temperance Society, was founded. Nine people attended a meeting in July, and by the following February there were 247 members. A chapter of the same society was also formed in Quebec City (Blais-Hildebrand, 1975), in New Brunswick (Chapman, 1954) and most probably in Ontario. The members were former drinkers who spoke publicly about their conversion experiences. The importance of this society, apart from the fact that it was the ancestor of Alcoholics Anonymous (Blumberg, 1977), was its concern for those suffering from alcoholism.

They [the temperance reformers] knew what most non-alcoholics did not: that beneath the repellent exterior of the drunkard there was frequently a sensitive and troubled personality seeking any sign of kindness that might be offered, desperately hating the addiction, but, without help, unable to shake it.

(Birrell, 1977:28)

The Washingtonians flourished from 1840 to 1845 and then disappeared. With the dissolution of the movement came a decrease in the understanding of and concern for drinkers. The moral model came to predominate: drunkards were seen as wicked sinners who drank of their own free will and could not be helped.

From the dismantled Washingtonians sprang the Sons of Temperance and then the Daughters and the Cadets of Temperance.

The Sons of Temperance was well organized and had a definite structure, and its meetings followed a well-defined ritual. It has, therefore, some of the earmarks and appeal of a secret society.

(Chapman, 1954:50)

These societies, linked to the American chapters, were also present in Montreal (Blais-Hildebrand, 1975), in New Brunswick (Chapman, 1954), in Nova Scotia (Forbes, 1971), and in Ontario (Birrell, 1977).

The Second Temperance Wave: 1854 to 1874

The disappearance of the Washingtonians in the middle of the nineteenth century changed the nature of the Canadian temperance movement. With the birth of the Sons and Daughters of Temperance, the movement no longer called for temperance, but for abstinence. The use of fermented alcoholic beverages was also banned. There was the growing sense that the educational strategies promoted by the temperance societies had failed, and that alcohol was such a potent substance that it created problems more rapidly than the temperance workers could solve them (Birrell, 1977). The struggle to give up alcohol was not only a slow and painstaking process for many individuals; it did not always end in total abstinence. Temperance workers came to believe that the only foreseeable solution to the problem of alcoholism was to remove the poison from the market through the rule of law. Prohibition thus became the answer to this uncontrollable evil. The prohibitionists constituted a powerful lobby. They had money and political influence. They believed in social reforms and were convinced that God was on their side.

In response to the growing perception that legal strategies were the answer, several laws were adopted by the Canadian Parliament. *The Scott Act of 1864* and the *Temperance Act of 1874* were the most significant. The latter allowed each county to adopt Prohibition laws by referendum. It is not the purpose of this chapter to describe the effects of these laws in Canada, since it has been done elsewhere (Decarie, 1970, 1974; Forbes, 1971, Spence, 1919). The reader should note, however, that Canadian legislation made each county sovereign over alcohol control. This built-in decentralization of alcohol policy led to a great variety of responses in Canadian regions: some went dry, others tolerated alcohol. In certain parts of the country, Prohibition lasted for a long period; in others, the legislation was rapidly repealed.

It is interesting to note that most parts of English-speaking Canada were dry, at one point or another, from the mid-

nineteenth century until the First World War. The first restrictive legislation was adopted in New Brunswick in 1855. Although Prohibition was enforced through a democratic process, it was rarely completely complied with. The black market was prosperous, and many offenders built small and large fortunes by distilling and selling spirits. Bootlegging was for many a highly well-paying business. The prosecution of offenders also brought significant income to municipalities. In his study of Moncton, New Brunswick, in 1889–90, Couturier (1985) suggests that the city maintained restrictive laws for alcohol because of the profit generated by the fines. In short, Prohibition was kept precisely because it did not work!

In Lower Canada, voting for Prohibition was linked to language. The English-speaking Eastern Townships, with their strong Loyalist constituency, voted for Prohibition. In contrast, very few French-speaking counties made that choice. The Ultramontane clergy, known for their opposition to the separation of church and state, exercised considerable political power in Quebec in the latter half of the nineteenth century. They used this power to prevent the implementation of Prohibition in Quebec on the grounds that it was a secular law that interfered with church jurisdiction. The drinking of alcohol was a moral question, they argued, and therefore any pronouncement on its use was a matter for the church and not the state.

For some Canadians, the ideal of an alcohol-free society stemmed from the desire to remake the world in accordance with what they considered to be the highest moral values, as set forth by evangelical Protestantism. Forbes, a Canadian historian, in his writing on the Prohibition movement in Nova Scotia, affirms that the "popular image of the prohibitionists as frustrated puritanical zealots bent on suppressing the pleasures of others rapidly breaks down... . They wanted to create a new society in which crime, disease, and social injustice would be virtually eliminated" (1971:11). Freeing Canada from alcohol was part of a master plan of social reform. Be that as it may, temperance literature had its heroes and villains. Its main theme, working-class drunkenness, was presented by two protagonists: an irresponsible male and a female victim. The portrait of the habitual drunkard, depicted by Mr. Clarke before the Royal Commission on Liquor Traffic, was redrawn with minor variations by other temperance advocates, concerned with the public good.

> *I know one case of a persistent drunkard who is unfortunately related to myself, and the poor unfortunate woman, his wife, will go out and work hard and earn a few dollars scrubbing or washing paint, and she will buy meat and bread for her five children. There is no doubt there is something wrong with the children; the eldest boy, I think, is all right, but there is something wrong with the other four, and I say it comes from the whiskey. I have known repeatedly after she got her meat and bread, that her husband would come and snatch the meat off the stove and those children round at the time were helpless.*
>
> *(Royal Commission [1895–96], Vol. 2:535)*

It was in the paradoxical context of extreme intolerance toward drunkards standing alongside a strong commitment to bringing about moral reforms that women entered the forefront of the temperance movement.

The Woman's Christian Temperance Union

The Woman's Christian Temperance Union (WCTU) was founded in Cleveland in the fall of 1874. Beginning in Ohio in the winter of 1873 and spreading to 22 additional states, women organized themselves in groups to persuade innkeepers, drugstore owners, saloon goers and local licensing boards that drinking alcohol was an evil and had to be stopped. The first crusaders were well-educated, respectable, middle-class, Protestant church women. They were driven into action by an 1870 amendment to the *Ohio State Liquor Law*, which permitted mothers and wives of drunkards to sue saloon keepers and liquor vendors for damages arising from the sale of alcohol to their spouses and sons. They went from court to court arguing cases of male drunkenness on behalf of female victims.

Organizing support demonstrations and prayer meetings of women and children, which confronted drinkers and saloon keepers on their own turf, proved highly successful. These often spontaneous anti-drinking protests closed down thousands of saloons across the United States, if only temporarily. Women armed with Bibles, prayers and temperance songs entered business premises with the intention of convincing owners to stop selling alcohol. In their enthusiasm for their cause, these "good Christian ladies" found themselves kneeling in prayer on beer-soaked floors, subject to harassment, which included arrest. Their tactics of direct action, considered shocking and radical by middle-class standards, contrasted with the more conservative nature of their message: "for the protection of the home, the abolition of the liquor traffic, and the triumph of Christ's Golden Rule in custom and in law" (McGovern, 1977:14).

The Canadian Scene

In the same year, 1874, the Prohibition message of the WCTU (without its more radical practices) was carried to Canada by Letitia Youmans, a native of Ontario and a delegate to the founding conference of the WCTU. Youmans, a charismatic leader, played a pivotal role in making the WCTU a pan-Canadian organization with unions in every province. The organization was not, in fact, the first all-female temperance society in Canada; the Ladies' Total Abstinence Society of Saint John, New Brunswick, predates it by 27 years. The WCTU was, however, the most influential. By 1900, its membership had reached approximately 10,000, making it the largest woman's reform organization in the country.

The members of the WCTU felt that the qualities associated with their sex particularly qualified them as reformers of society's taste for strong drink. As middle-class women, they believed it was their moral duty – and therefore their right – to protect the home from society's ills. Didn't women's maternal instinct and their more developed moral sense equip them to take a leading role in the fight against intemperance? In fact, the discourse of the WCTU was as much about changes in gender roles as it was about changing attitudes toward alcohol consumption.

Indeed, it was the Victorian middle-class ideal that was held up as the model of family life for the working class – whose domestic life was believed to be endangered by the intemperate habits of its members. The role of moral guardian, handed down to middle-class women, gave them (in the guise of charity work) the freedom to cross class boundaries into realms otherwise forbidden to respectable members of their sex. Their entrance into the homes of the poor served as a first-

hand lesson in the hardships of the needy. Their visits also convinced them that alcohol, and not male unemployment or female economic dependence, was responsible for such misery. For those women who joined the WCTU, Prohibition provided an easy solution: rid the country of alcohol and social evils would disappear. It was a comforting answer that did not threaten their privilege or the sense of self-worth they derived from "saving" the more unfortunate of their sex. They argued that alcohol destroyed a man's ability to fulfil his role as breadwinner and thus forced his impoverished woman to assume the role of wage earner. By temporarily abandoning their maternal role, poor women presented a challenge to the naturalness of family relationships organized around rigid sexual divisions. Alcohol effectively undermined the established boundaries that defined gender relations (Harvey, 1991).

The view that women were the ultimate saviors of the family had profound consequences. It meant that, in practice, women were blamed for male drunkenness. As a result, it was left up to women to reform the drinking habits of their mates. The social importance of implications of the female role came out in testimony presented before the Royal Commission on Liquor Traffic.

> *The artizan [sic] is generally weak in character and he does not escape temptation; but if his wife accompanies him and keeps him in her hands, as is the common saying, he would meet her wishes [and] no longer swerve from the right path... .*
>
> *(Mr. Gigault, Minutes of evidence, Royal Commission [1895–96], Vol. 2:215)*

Temperance Discourse and Women

If the male drunkard was a central figure in the temperance discourse, such was not the case for the female drunkard. Ideas about female purity precluded any sustained discussion of women's drinking. If alcohol turned men into beasts, whose brutishness could only be quelled by the virtuousness of a kind and loving woman, the opposite scenario, of alcohol turning a woman into a beast whose brutishness is quelled by the virtuousness of a good and loving man, was unthinkable. Abstention from alcohol became incorporated into the very definition of what was considered female. Subsequently, women who did drink were not only considered unwomanly, but this also called into question their very femininity (Tyrrell, 1991). In fact, temperance discourse served the dual purpose of criticizing men's drinking habits while policing those of women. It also threw a cloak of invisibility around women who drank.

The silence of female temperance advocates on the question of female drinking can also be looked at in the light of their self-appointed role as guardians of public and private morality. The rarity of any serious discussion of female drinking by WCTU women might suggest that few middle-class women drank heavily, but this supposition seems doubtful. A more probable assumption is that social condemnation drove women to drink in private: "The middle-class lady cannot help herself openly to two or three whiskeys or brandies, as a man will do" (Chesser, 1909; quoted in Krasnick Warsh, 1989:4). A woman was valued and in turn valued herself as "The Virtuous Woman." It was a powerful image, central to the structure of the middle-class ideal of the family. The raising of too many examples of women

who did not uphold this standard would have threatened the whole ideal.

To admit that drunkenness existed among poor and working-class women posed slightly less risk. The strongest condemnation was reserved for the "fallen woman," whose drunkenness allegedly propelled her down the slippery slope to prostitution. Equally repellent was the stereotype of the mother whose maternal instinct was diluted by alcohol.[7] These examples of femininity gone wrong, numerous throughout temperance literature (Levine, 1980), were clearly incompatible with the respectable image of womanhood endorsed by WCTU women and others. Female drinking was viewed as *the* insidious force that threatened to topple the family, a miniature state that elevated and was ruled by women.

In fact, drunkenness could undermine a woman's ability to care for others. It could deprive fathers and husbands of female labor, considered essential to their continued well-being. In a time when meal preparation and the maintenance of basic standards of cleanliness were highly labor intensive, men and children were dependent on women for their physical survival. A woman who drank could not hope to meet the growing list of needs outlined by exponents of the new child-raising practices. The story of a wife whose love of drink interfered with her abilities as a housekeeper dramatized the conflict between a woman's individual desires and the selflessness demanded of her as wife and mother. Society strongly censured the alcoholic woman who put her desires before those of her husband and child. Thus, one Toronto social worker could claim that "drunkenness among women is 10 times worse than in men, because it causes them to lose their maternal instinct and feeling, and they become thoroughly degraded" (Mr. Kelso, as quoted by Rev. J. M'Leod, Royal Commission, Vol. 6 [1896:529]).

Conclusion

Did the ideas put forth by the temperance movement represent a break with or a continuance of past attitudes toward women's drinking? The authors have recounted the Romans' prejudiced views on female intoxication. A work in progress by Jessica Warner (1992) indicates that in late medieval Europe, society viewed men's and women's drinking in different lights. During that age, women had less access to alcohol than did men at times of restriction. With regard to drinking (and other behaviors), different standards were applied to the sexes. Women's drinking habits were more closely and critically scrutinized. The temperance movement of the nineteenth century helped push society's less permissive attitude regarding women's drinking toward a fully fledged double standard. By the end of that century, women's drinking had become thoroughly stigmatized.

In the last part of the century, the Cult of True Womanhood served to codify the notion of women's moral superiority for the nineteenth-century public. In this social context where men drank to excess, women's presumed moral superiority made them responsible for their husbands' and sons' drinking. Women paid heavily for this responsibility. Those who failed to stop a drunken relative were considered as guilty, if not more so, than the drunk himself. Women who failed to conform to the norm by being drinkers themselves were seen as "less than women" or "fallen angels" (Fillmore, 1984). The social process by which women are still held responsible for men's drink-

ing, and by which they are still seen as degraded when they themselves abuse alcohol, can be understood as part of the legacy of the temperance movement.

Today, alcoholic women are still held in greater contempt than are their male counterparts (Blume, 1991; Knupfer, 1982). An intoxicated woman is seen as possessing less self-control and dignity than a man in the same condition. This social condemnation has been internalized by many women. In a recent study, 95 per cent of the alcoholic women and 85 per cent of the control group reported that "social attitudes towards female intoxication and problem drinking are more rejecting than they are towards the same behavior by males" (Lisansky-Gomberg, 1988:509). Furthermore, women admitted for treatment for alcoholism exhibit a higher prevalence of psychiatric disorders than their male counterparts (Helzer & Prybeck, 1988; Hesselbrock, Mayer & Keener, 1985; Schuckit & Morissey, 1976). In 1990 at Domrémy Montréal, a public treatment centre (Guyon & Landry, 1993), higher rates of depression and anxiety were found among female than male clients, as well as a 60 per cent higher incidence rate of lifetime suicide attempts (six per cent for women vs. four per cent for men). These figures suggest that a woman must experience greater personal distress than a man to resort to alcohol abuse, or that alcohol abuse causes greater damage to a woman's self-esteem. Even in the 1990s, heavy drinking by women is still construed as a transgression against established gender codes of behavior.

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Notes

1. An earlier version of this chapter was published in *Addiction Research*, 2(3), 1994.

2. Chapman (1954), pp. 44–5. It is intriguing that Magnus Huss, the Swedish physician who introduced the word "alcoholism" in 1849, became interested in alcohol abuse because of his anger, as a young military physician, at being paid part of his salary in *bränvin*, a distilled spirit (Sournia, 1986).

3. Since Canadian research has not yet revealed anything about consumption patterns of women prior to 1840, or the nature of the social attitudes toward female drinking and intoxication, the present authors do not make any inferences about such patterns.

4. It is of interest to note that John Wesley (1703–1791), the English founder of the Methodist Church, recommended that the members of his congregation abstain from all distilled spirits and, in 1784, forbade its use to the pastors of the church. He also demanded the Prohibition of all distilleries (Sournia, 1986). Thus, there was a tradition of temperance in the Methodist Church.

5. This position was reiterated throughout the nineteenth century. One can find it in the newsletters of the anglophone temperance societies and in Chiniquy's *Manuel de tempérance* (1847). The Royal Commission on Liquor Traffic (1896) and Ruth Spence (1919) also shared such views about alcohol and therefore proposed a prohibitionist solution to free Canada from it.

6. The term crusade refers to the attempt to mobilize the masses in favor of an idea, a cause, a movement. It relates to the term that denoted the many campaigns sanctioned by the church in the Middle Ages against the unbelievers or heretics. A crusade resembles a campaign, but lasts longer; within a crusade, there may be many campaigns, just as there were many temperance waves in the nineteenth century (Voisine, 1979; *Webster's Third International Dictionary of the English Language* [unabridged], 1976). See, for the United States, Gusfield (1963), *The Symbolic Crusade*.

7. Ironically, it was the call to promote the notion of the respectable woman as Mother (a role that has served to keep women within the home) that gave middle-class women a means of escaping the confines of their condition. It provided justification for their entry into a larger, public world otherwise denied to them.

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CHAPTER 4

Young Women: Alcohol, Tobacco and Other Drugs

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The concern about drug use among youth in Canada has had much play in the media in recent years. Numerous national and provincial surveys have attempted to document the nature and extent of the use of both legally sanctioned drugs (e.g., alcohol, tobacco, over-the-counter and prescription drugs) and illicit drugs (i.e., drugs purchased on the street). Ironically, the "war on drugs" strategy focuses on the latter, while in reality alcohol and tobacco continue to be the drugs that most seriously affect the health of Canadian youth (Solomon, 1991).

Drawing on the available literature, this chapter discusses the trends in substance use over the last decade among young women 15 to 19 years of age. In particular, it offers an overview of the current situation and an analysis of data from the 1989 National Alcohol and Other Drugs Survey (NADS). Finally, it provides an analysis of the problem of drug use among young women, linking their subordinate position in society to the manifestation of their drug problems and their opportunities for finding help.

General Comments on Drinking and Other Drug Use

Among young women, the period from mid-teens to mid-twenties marks a transition from adolescence to womanhood, with increased stress and peer pressure to belong accompanied by a search for autonomy. As young women move through adolescence, tobacco and alcohol use becomes legal, and licit and illicit drugs are more available. It is not surprising, then, that this period of transition

may include a shift from the relatively minor use of substances to heavier use. Of all age groups, women in their teens and twenties are most like their male counterparts in their use of substances. Nevertheless, they experience social pressures and contexts that are unique to women in our society.

Since the most popular means of determining drug use trends among young people has been national or school surveys, it is important to highlight some of their methodological limitations.

First, there is the likelihood that young women who are in trouble with alcohol or other drugs will be underrepresented if survey questionnaires are distributed in the classroom or are carried out through telephone calls to the home. Adolescents who are heavy users may have dropped out of school, or may be living on the street or in an institutional setting such as a group home.

Second, the emphasis in surveys has been on the use of illicit drugs, alcohol, and more recently, tobacco. Substances such as solvents and inhalants, used mainly by young adolescents, are not always included.[1]

For these reasons, survey findings should be considered as conservative and, therefore, an underestimated representation of drug use (Adlaf & Smart, 1991).

Alcohol, the Popular Drug

National Trends

Since 1978, there have been four national surveys on substance use by Canadians (Table 4.1). Although the percentage of young women who are current drinkers has not changed substantially over the past decade, there has been a notable increase in the percentage of former drinkers, while the percentage of non-drinkers has declined.[2] The percentage of former drinkers increased from three per cent in 1978 to 17 per cent in 1989, while during the same time period non-drinkers decreased from 21 per cent to 11 per cent.

Table 4.1
Alcohol Use by Adolescents 15-19 Years, Canada

Survey	Type of Drinker		
Total	Non-drinker percentage	Former drinker percentage	Current drinker percentage
CHS (1978-79)			
1,146 F	21	3	71
1,187 M	16	1	74
GCS (1985)			
945 F	24	4*	71
993 M	22	3*	74
CHPS (1985)			
956 F	11	8*	81
1,001 M	7	10	82
NADS (1989)			
910 F	11	17	73
956 M	12	12	76

* High Sampling Variability

Sources: Canada Health Survey [CHS] (Health and Welfare Canada and Statistics Canada, 1981); General Social Survey [GSS] (Statistics Canada General Social Survey Analysis Series, 1987); Canada's Health Promotion Survey [CHPS] (Health and Welfare Canada, 1988); National Alcohol and Other Drugs Survey [NADS] (Health and Welfare Canada, 1990).

According to the Canada Health Survey (Health and Welfare Canada and Statistics Canada, 1981), girls and boys begin drinking at much the same age. About a third begin drinking between

14 and 15 years of age, followed by another third between the ages of 16 and 17. Eleven per cent of the girls and 14 per cent of the boys begin drinking before age 14. This early onset may, in part, explain the increase in former drinkers. It may be that young people who begin drinking at an earlier age encounter problems with use and subsequently decide to stop.

Provincial Surveys

Provincial and local surveys among students over the last decade generally show a decline in alcohol use among junior and high-school students (Smart & Adlaf, 1989; Jeune, 1986; Campbell, 1989; Mitic, McGuire & Neumann, 1989). For example, among adolescent girls in Ontario, current drinkers declined from 74 per cent in 1977 to 65 per cent in 1989 (Smart & Adlaf, 1989).[3]

Community Studies

Community-based studies provide an understanding of drug use among specific hard-to-reach populations. A number of recent studies, including The Canada Youth and AIDS Study (King, Beazley, Warren, Hankins, Robertson & Radford, 1989), Street Youth and AIDS (Radford, King & Warren, 1989) and Drugs, Youth and the Street (Smart, Adlaf, Porterfield & Canale, 1990) have made attempts to survey youth who are not in the school system, as well as more marginalized young people living all or part of their life on the streets.

The focus has been on the experience, knowledge, attitudes and behaviors of youth in their teens and early twenties. Among Toronto street youth surveyed by Smart and his colleagues, eight per cent of young women on the street were daily drinkers, 18 per cent had had 29 or more drinks in the previous seven days, and 22 per cent had had five or more drinks on a single occasion, five or more times in the previous four weeks. Not surprisingly, a substantial proportion acknowledged alcohol problems.

Similarly, the national surveys carried out as part of the Canada Youth and AIDS Project (King et al., 1989; Radford et al., 1989) revealed that school dropouts and street youth were more likely to be drinkers than those in either high school or college. Young women dropouts or those living on the street were also more likely to be weekly drinkers, or to drink five or more drinks at one time, than young women attending school.

International Comparisons

In the United States, there have been continuing surveys of high school seniors undertaken by the National Institute of Alcohol and Alcohol Abuse (Johnston, O'Malley & Bachman, 1989). Youth 12 to 17 years old have also been included in the National Survey on Drug Abuse (NIDA, 1990). Both these surveys provide trend data indicating that alcohol use is either stable (NIAAA 1975–89) or in decline (NIDA 1985–88). When compared with their American counterparts, Canadian youth are "more likely to report that they drink (81 per cent vs. 52 per cent), less likely to use cannabis (12 per cent vs. 20 per cent) and cocaine (2 per cent vs. 4 per cent)" (Adlaf & Smart, 1991:60).

It is generally accepted that, while young women are consumers of alcohol alongside young men, young men drink more frequently and in greater quantities. However, we must be cautious in assuming that alcohol consumption among young women should not be a major concern. Drink for drink, females are more vulnerable to the effects of

alcohol than are males, because of their usually smaller size and lower levels of body water in which to dilute the alcohol.

A Closer Look at Alcohol Use

The NADS survey offers an opportunity to examine further the current use of alcohol among young Canadian women aged 15 to 19 years. As young people age, there is a tendency for alcohol use to increase. This pattern was clearly recognized in the NADS sample. As stated earlier, of the young women aged 15 to 19 years, 73 per cent reported being current drinkers. Not surprisingly, 17- to 19-year-old adolescents are more likely to be current drinkers than younger adolescents (76 per cent vs. 66 per cent).

Given the increased availability, acceptance and promotion of alcohol, the reasons young women choose not to drink are of interest. Among the 28 per cent of those 15 to 19 years old who were non-drinkers, the primary reasons given for abstaining were: not liking the taste of alcohol (37 per cent), having seen bad results of what alcohol can do (30 per cent) and health reasons (23 per cent) (Table 4.2).

Table 4.2
Reasons Given for Not Drinking by Young Women (15-19 Years Old)

Reasons	Percentage (n=117)
Did not like taste	37
Have seen bad results	30
Health	23
Did not like effect	16
Upbringing	15
Waste of money	9
Diet/Athletics, etc.	5
Afraid of becoming dependent	4
Religious reasons	2
Other	21

Young Women Drinkers

The vast majority of young women describe themselves as drinkers, and the primary reasons cited for drinking were: to be sociable (64 per cent), to feel good (39 per cent), to add to the enjoyment of meals (30 per cent) and to relax (30 per cent).

Table 4.3
Reasons for Drinking Given by Young Women (15-19 Years Old)

Reasons	Percentage (n=322)
To be sociable	64
To feel good	39
To add enjoyment to meals	30
To help relax	29
To feel less inhibited/shy	27
To forget worries	17

Drinking is indeed a social activity, and 93 per cent of current drinkers report that they never drink alone. Among drinkers in this age group, 89 per cent drank with friends from a few times a year to one or more times a week, while 72 per cent drank with family or relatives, five per cent with spouse or partner, and 22 per cent with co-workers.

There was a significant relationship between age and drinking to feel good (X^2= 4.75, p<0.029, n=322)[4] and age and drinking to feel less inhibited or shy (X^2=4.32, p<0.038, n=322). Those in the younger age group (15 to 16 years) were more likely than those in the older age group (17 to 19 years) to report that they drank to feel good or to feel less inhibited. Such reasons for drinking as "to be sociable" and "to add enjoyment to meals" reflect the social use of alcohol, whereas such reasons as "to feel good," "to feel less inhibited/shy," "to forget worries" or "to help relax" reflect the use of alcohol as a drug.

Current drinkers were asked a number of questions to determine their frequency and quantity of intake and the extent of their excessive drinking, if any. When considering alcohol use in the week prior to the survey, 66 per cent did not drink, 29 per cent drank between one and seven drinks, and five per cent drank eight or more drinks. While overall frequency may be low, young people more often exhibit a pattern of episodic rather than daily drinking. When the young women were asked to report the number of times they drank five or more drinks on any one occasion in the past 12 months, 30 per cent had done so on one to two occasions and 27 per cent had done so three or more times, while 11 per cent had engaged in this type of heavy episodic drinking 12 or more times during the previous year.

When age is considered, again there is a significant difference in heavy episodic drinking between those in the 15- to 16-year-old age group and those in the 17- to 19-year-old age group (X^2=12.17, p<0.00048, n=320). Those in the older age group more often reported doing this three or more times during the previous year (33 per cent) than did those in the younger age group (14 per cent). This level of drinking may well put young women at risk for the acute effects of alcohol.[5]

The young women surveyed are mainly drinkers of beer (42 per cent) and wine (32 per cent), while 28 per cent report also drinking mixed liquor. Given the general preoccupation with weight and calories in this population, it is surprising that only nine per cent indicated they usually drank light beer.

Harmful Effects of Alcohol Use

The presence of negative effects from alcohol consumption often indicates problematic use. Young women reported that there were times when their drinking had a harmful effect on friendships (nine per cent), their health (eight per cent) and their general happiness (five per cent). The prevalence and degree of problematic use of alcohol is illustrated by the fact that 29 per cent said that they had a friend with a drinking problem.

Attempts to Reduce and Quit

A number of young women, after drinking for a period of time, had decided either to quit (35 per cent) or to reduce the amount they drank (28 per cent). The most frequent reasons cited included dieting, pregnancy or athletic training (31 per cent), the belief that they were drinking too much or had a drinking problem (20 per cent) and the influence of family and friends (19 per cent) (Table 4.4). Young women were least likely to report reducing or quitting drinking because it was affecting work or studies (eight per cent).

Table 4.4
Reasons for Reducing or Quitting Drinking Given by Young Women (15-19 Years Old)

Reasons	Percentage (n=130)
Diet, athletics, pregnancy	31
Drinking too much	20
Influence of family/friends	19
Effect on physical health	14
Effect on friendships	14
Effect on happiness	12
Effect on financial position	12
Getting older	9
Interfering with family life	8
Effect on work/study	8

When considering age, significantly more older teens aged 17 to 19 years (18 per cent) cited effects on physical health as a reason to reduce or quit drinking compared with younger teens aged 15 to 16 years (three per cent) (X^2=4.59, p<0.032, n=131).

When considering the strategies used to reduce or quit drinking by these young women, by far the most common were limiting the number of drinks (82 per cent), changing drinks (50 per cent) and changing activities (39 per cent). Among the women who had reduced their alcohol use, 52 per cent were continuing to drink, though at a moderate level.

Less than one per cent indicated they had used any services to assist them with alcohol problems. This may be due, in part, to the lack of services for young people and the fact that the help that is available is geared to "alcoholics," with programs requiring total abstinence for all participants. It also suggests that the young women felt they were able to moderate or stop drinking on their own.

Experiences with Other People's Drinking

The findings of the NADS clearly indicate that many of the young women surveyed were dealing with the effects of other people's drinking problems (Table 4.5). In their relationships with people who were drinking, almost half the women reported being insulted or humiliated (49 per cent), experiencing serious arguments (44 per cent) and experiencing serious family problems (24 per cent), while one-fifth reported being pushed, hit or assaulted (20 per cent). Of those who reported incidents of physical assault, those in the 15- to 16-year-old age group (25 per cent) did so to a greater degree than those in the 17- to 19-year-old age group (17 per cent) (X^2 = p<0.05).

There are some gender differences in these experiences. Young men are less likely than young women to report being insulted or humiliated (38 per cent), having arguments and quarrels (31 per cent) and having family problems (13 per cent). In terms of incidents of physical violence, slightly more young men reported being pushed, hit or assaulted, but there were no significant age differences in general for men.

Table 4.5
Experiences with the Drinking of Others: Young Women (15-19 Years Old)

Experiences	Percentage
Been insulted or humiliated	49
Been disturbed by people drinking	44
Had serious arguments	44
Been a passenger with drunk driver	29
Had family problems	24
Been pushed, hit or assaulted	20
Had friendships break up	17
Had property vandalized	14
Been in car accident	4

General Trends in Tobacco Use Among Females

Overall, use of tobacco in Canada has declined gradually since 1965. This decline can be seen in those who are 15 to 19 years old (Eliany & Courtemanche, 1989). A glance at the last decade indicates relatively little change in prevalence of use over the last three years (Table 4.6). The prevalence figures for males in the same age group from the NADS are also provided and are virtually the same as those for females.

Table 4.6
Adjusted Prevalence of Current Cigarette Smokers (15-19 Years Old), Canada, 1979-89

Year	Females Percentage	Males Percentage
1979	46	47
1981	42	45
1983	39	38
1985	28	26
1986	28	24
1988	23	20
1989	24	22
1990	21	21
1991	26	20
1994	29	26

Note: Estimates for 1979, 1981, 1983 and 1986 are from the Labour Force Surveys, 1985; the General Social Survey, 1988; and the Campbell Survey on Well-Being in Canada. Estimates for 1989 are from the National Alcohol and Other Drugs Survey. The data from the various surveys has been reprinted in *Canadians and Smoking: An Update* (Health and Welfare Canada, 1991).

While statistical findings present an optimistic picture regarding young women and tobacco, a number of researchers and female health activists have raised concerns regarding current marketing strategies of the tobacco industry and the vulnerability of young women to nicotine addiction (Greaves, 1987).

Children and women are clearly the focus of market expansion for tobacco companies (Pollay, 1991). In Ontario, a coalition of more than 20 health groups has organized a campaign to prevent the tobacco industry from targeting children in their advertising (*The Journal*, 1992).

In designing programs to prevent the onset and maintenance of smoking, it is helpful to be able to identify population subgroups that are likely to begin and continue smoking. In order to begin this identification process, a series of bivariate analyses were conducted to assess relationships between smoking status (current, former and never smokers) and several sociodemographic, psychosocial and lifestyle variables. Cross-tabulations were used for categorical variables (such as marital status and religion) and the analysis of variance for continuous variables (such as amount smoked or consumed).

Sociodemographic Characteristics Related to Smoking

As can be seen from Table 4.7, there were more young women smokers in Quebec and the Prairies, followed by the Atlantic region and British Columbia, with the lowest numbers found in Ontario. This particular geographic pattern has not been found in adult females (Health and Welfare Canada, 1991). In spite of these regional variations, when young women were questioned about their language and culture, no differences emerged in terms of proportions of smokers in the various categories; however, there were more former smokers in the non-English speaking group.

Table 4.7
Smoking Status by Region: Young Women (15–19 Years Old)

Status	Atlantic (n=45)	Quebec (n=109)	Ontario (n=159)	Prairies (n=84)	B.C. (n=49)
			Percentage		
Never	59	47	82	55	63
Former	11	18	3	13	17
Current	29	35	11	31	20
Pearson $X^2 = p<0.001$					

Source: National Alcohol and Other Drugs Survey (Health and Welfare Canada, 1990).

While the numbers are quite small, there appear to be higher levels of smoking among those who worked or were looking for work, and among those who were married or living in a common-law relationship, than among those of other employment or marital statuses (Table 4.8).

Table 4.8
Smoking Status by Work Status, Marital Status and Religiosity: Young Women (15–19 Years Old)

Status	Yes	No
	Employed/Looking for Work	
	(n=84)	(n=358)
	Percentage	
Never	50	67
Former	19	11
Current	31	22
Pearson $X^2 = p<0.01$		
	Married/Common Law	
	(n=26)	(n=418)
	Percentage	
Never	19	67
Former	13	12
Current	68	21
Pearson $X^2 = p<0.001$		
	Very/Moderately Religious	
	(n=232)	(n=148)
	Percentage	
Never	68	59
Former	13	9
Current	18	32
Pearson $X^2 = p<0.008$		

Source: National Alcohol and Other Drugs Survey (Health and Welfare Canada, 1990).

Psychosocial and Lifestyle Factors

Previous investigations have found that smoking and other drug use is related to personality characteristics, motivational factors (such as stress) and personal resources (including coping skills and social support) (e.g., Castro, et al., 1987). However, there were no statistically significant relationships found between smoking status and either reported stress or reported helpfulness of family or friends among the 15- to 19-year-old women in the NADS.

As for lifestyle factors, no consistent pattern was observed with regard to participation in physical activities. This is in spite of numerous studies that have shown that individuals participating in sports are less likely to smoke than are non-participants (Ibsen, 1982; Stones, Kozma, McNeil & Stones, 1986). However, there were more smokers among those who considered themselves religious (Table 4.8), those who used medications and illegal drugs (either "ever" or "within the past year") (Table 4.9) and those who were more likely to be current drinkers (Table 4.9), as reported elsewhere (Smart & Adlaf, 1989).

There is seemingly some awareness of the impact of smoking on health, as evidenced by the tendency of those who report higher levels of perceived health to be less likely to smoke than those who report that their health is not "excellent" or "very good." In spite of reports that young women smoke in order to control their weight and that lower body weight and skinfold thickness are found for smokers as compared to non-smokers (Stephens, Pederson & Hill, 1983; Wittsten, Guarino, Lisbin & Dougherty, 1988), no relationship was found between smoking and body mass index (BMI = weight/height^2).

Table 4.9
Smoking Status by Drug and Alcohol Use: Young Women (15–19 Years Old)

Status	Yes	No
	Illicit Drugs Used Ever	
	(n=105)	(n=340)
	Percentage	
Never	24	76
Former	22	9
Current	54	14
Pearson $X^2 = p<0.001$		
	Illicit Drugs Used in the Last Year	
	(n=47)	(n=398)
	Percentage	
Never	28	68
Former	23	11
Current	49	21
Pearson $X^2 = p<0.001$		
	Current Alcohol User	
	(n=323)	(n=122)
	Percentage	
Never	57	84
Former	15	5
Current	28	11
Pearson $X^2 = p<0.001$		

Source: National Alcohol and Other Drugs Survey (Health and Welfare Canada, 1990).

Prescription, Over-the-Counter (OTC) and Street Drugs

Although national Canadian surveys (Canada Health Survey, Canada's Health Promotion Survey and the NADS) have collected information on the use of prescription drugs and analgesics, the rates of use were either too low to be reported or the surveys used different age groups, making it difficult to discern trends over time.

The reports of drug use within the 30 days previous to the NADS show that, other than marijuana/hashish (10 per cent), very few young women had used street drugs (Table 4.10) or Valium, stimulants, sleeping pills or narcotics (such as morphine, Demerol and codeine) (Table 4.11).

Table 4.10
Street Drugs Used in Previous 30 Days: Young Women (15–19 Years Old)

Drug	Percentage (n=426)
Marijuana/hashish	10
Cocaine/crack	1
LSD(Acid)	1
Speed/amphetamines	1
Heroin	<1

Table 4.11
Prescription and OTC Drugs Used in Previous 30 Days: Young Women (15–19 Years Old)

Drug	Percentage (n=426)
Pain relievers/Aspirin	63
Cough/cold remedies	33
Allergy medicine	13
Stomach/laxatives	10
Codeine/Demerol/morphine	5
Sleeping pills	2
Diet pills/stimulants	1
Valium	<1

Source: National Alcohol and Other Drugs Survey (Health and Welfare Canada, 1990).

On the other hand, Aspirin and pain relievers were used by 63 per cent of the women, with 22 per cent by prescription. This figure is greater than that found for young men, among whom 56 per cent reported usage, with 13 per cent by prescription.

A significantly higher number of young women who described their lives as stressful were users of aspirin and pain

relievers. Also, current drinkers reported higher use of analgesics in the previous 12 months than non-drinkers.

Frequent use of analgesics among young women is not unique to Canada.[6] In Australia, it has been noted that "what the drink habit is to men in Australia, the headache powder is among women" (Murray, 1980). While there are a number of harmful effects accompanying constant use of ASA-related drugs, the most severe danger is permanent kidney damage, often referred to as analgesic nephropathy.

Again, less than one per cent of young women have ever used any services for help with drug concerns. Use of illicit drugs is minimal, and over-the-counter and prescription drugs are most likely viewed as medicinal and necessary.

Conclusion

The continuing outcry about the devastation caused by drug use (with primary emphasis on street drugs) gives little attention to drugs such as alcohol and tobacco or to the social conditions of the young people who use them. There is growing support for the view that inadequate social conditions are a major factor in the destructive use of drugs (Alexander, 1990). There is some evidence that stressful life events are connected to adolescent use of substances such as alcohol. The use of drugs is believed to lessen feelings of lack of control, meaninglessness and alienation in the stressful lives of young people (Newcomb & Harlow, 1986). Other researchers have focused on other factors that moderate the relationship between stress and drug use, such as self-esteem and peer and family relationships (Kumpfer & Turner, 1990-91; Thorlindsson & Vilhjalmsson, 1991). It has been suggested that persons without social support from friends or family tend to engage in activities that maintain problem situations or that create further stresses (Tucker, 1985).

Therefore, an awareness of the experiences of young women in this society is necessary for a full understanding of their use and overuse of drugs. Most general surveys offer only a limited understanding of the social context of respondents' lives. For example, it is known that in the NADS over half the young women surveyed aged 15 to 19 reported their lives to be very stressful or fairly stressful. Analyses have shown that women who report higher stress levels are also more likely to report drug use. Nothing is known, however, about the contributing factors or the toll this stress takes. Thus, it is possible to make only tentative speculations regarding this stress and its relationship to the use of alcohol and other drugs by these young respondents.

The pressures that young women face in our society often centre around attractiveness, getting along with peers and parents, restrictive expectations of what it means to be a woman and concerns for personal safety. Disturbing differences arise when the lives of young women and young men in Canada are compared. A recent study reports that

> *young women are less likely to feel they have good qualities, to feel self-confident, and to feel good about themselves. They are also less satisfied with their appearance, although their appearance is more important to them than it is to young men.*
>
> *(Holmes & Silverman, 1992:25)*

It is interesting to note that 13-year-old boys and girls are equally confident. However, by age 16, young women have already internalized the sexism of

society and feel less able and less worthy. The researchers conclude that "with [the] growing realization that society values them less than young men, young women's perceptions of themselves decline" (Holmes & Silverman, 1992:90).

The violence that women encounter in their lives, and the degree of tolerance with which it is accepted, gives them a clear message regarding their position in this society. Studies of high school and college students conducted during the 1980s have reported rates of dating violence ranging from 12 per cent to 65 per cent (Sugarman & Hotaling, 1989). Popaleni (1991) states that violence in these heterosexual dating relationships "comprises a series of systematic violations which include psychological abuse, physical battering and sexual coercion and assault" (p. 84). Whether young women are in the home, in the offices of physicians and other helping professionals, in their work or study environments or on the street, they are targets for abuse and violent attacks from men.

Again, the NADS finding that 20 per cent of the women surveyed aged 15 to 19 years reported being pushed, hit or assaulted by someone who was drinking, although disturbing, is not surprising. The authors are left wanting to know more about the nature and extent of the abuse. Such inquiry is important in light of the growing awareness that many women who seek help for drug problems have been sexually or physically assaulted as children and then later as adult women (Miller, Downes & Gondoli, 1987; Lundy, 1988; Covington & Cohen, 1984; Beckman, 1984).

Clearly, young women are not a homogeneous group. It is therefore essential that those in the field of health promotion develop an integrated approach to alcohol, tobacco and other drug use that seriously considers the influences of structured inequalities, such as class, gender, race, sexual orientation and differing abilities. An understanding of such social conditions and their effect on young women's use of mood-altering substances must be central to discussions of prevalence, treatment strategies, and prevention and health promotion if there is to be an effective attack on this still serious problem.

Notes

1. There are indicators that the use of Lysol, which is 67.7 per cent alcohol, is a growing problem. In the inner city of Edmonton, 1,644 empty Lysol cans were found during a five-week period in 1989 (Coates, 1991), while during the same time, there were reports of 27 cans found in one park in Ottawa (*Hunt Club News*, 1989).

2. The term "current drinker" refers to someone who has had a drink in the past 12 months, while "former drinker" refers to someone who has had a drink but not in the past 12 months.

3. The Addiction Research Foundation of Ontario has surveyed students in grades 7 and 13 since 1977 and provides the most comprehensive look at adolescent drinking and trends in use. A summary of these trends can be found in Smart and Adlaf, 1989.

4. X^2 stands for chi-squared; p stands for probability; n stands for sample. See Glossary for further explanation of statistical terms.

5. Women are more susceptible to the harmful effects of alcohol than men because their body mass is composed of more fat

and less muscle. Since there is little blood supply to fat, women have less body fluid than men and have a greater blood alcohol level after drinking. Women, therefore, suffer more from the effects of alcohol. Women who consume 20 g of alcohol (approximately two drinks) a day are at increased risk of developing liver cirrhosis compared with men who consume 40 g (New Report on Alcohol and Alcohol-Related Problems, 1986). Young women often have the additional risk of lower body weight.

6. See Murray (1980) for a summary of use.

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Salariées, chômeuses et femmes au foyer : l'alcool, le tabac, les médicaments psychotropes et les drogues : particularités de trois statuts d'emploi

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Une grande part de la documentation scientifique publiée récemment porte sur la consommation d'alcool, de tabac, de médicaments psychotropes et de drogues illégales chez les salariées, chômeuses et femmes au foyer. À la lecture de cette documentation, on constate une féminisation de l'usage de drogues légales et illégales chez les femmes âgées de 18 à 65 ans. Cette tendance générale est nettement représentée chez les femmes au travail. C'est sur ce phénomène que nous nous penchons dans le présent chapitre.

Le présent chapitre fait un survol de la documentation et des résultats les plus révélateurs de l'Enquête nationale sur l'alcool et les autres drogues (ENAAD, 1989) auprès des salariées, chômeuses et femmes au foyer[1] âgées de 20 à 64 ans. Ainsi, le lecteur verra si la consommation des Canadiennes de diverses catégories d'emploi rejoint celle des autres pays et si oui, de quelle façon. Les faits saillants de l'enquête sont présentés à la fin de ce chapitre.

Nous n'avons pas effectué un examen exhaustif des textes sur l'usage des drogues déjà énumérées. Nous nous sommes attardés de façon générale aux articles publiés pendant les dix dernières années. Nos sources sont surtout d'origine nord-américaine et européenne. Elles sont, pour la plupart, de type corrélationnel; quelques-unes sont qualitatives. Parmi ces études se trouvent des articles empiriques ou théoriques de revues et des thèses de doctorat. Il ne sera évidemment pas toujours question de consommation problématique. En effet, les différentes sources consultées portent sur divers niveaux de consommation : la consommation en général, la consommation à risque ou la consommation pathologique.

Le présent chapitre vise les objectifs suivants :

- donner un aperçu de l'importance quantitative de la consommation de drogues psychotropes (alcool, tabac, médicaments psychotropes et drogues illégales) chez les salariées, les femmes au foyer et les chômeuses;
- tracer le profil sociodémographique et présenter des portraits-types de consommatrices;
- circonscrire les pratiques et les motifs de consommation des femmes ;
- examiner les variables socioprofessionnelles (structurelles, organisationnelles ou relationnelles) et psychosociales liées à la consommation de drogues chez les femmes de diverses catégories d'emploi.

L'ampleur du phénomène

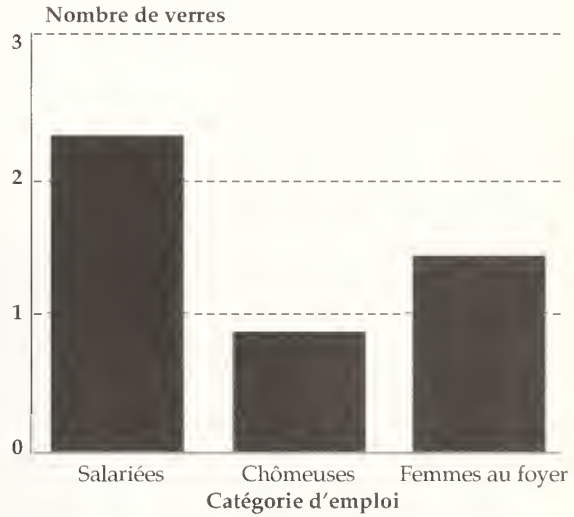
Données sur l'alcool

D'une part, plusieurs recherches qui tentaient d'étayer la thèse de convergence[2] ont démontré que la majorité des femmes consomment de l'alcool mais elles sont, en grande partie, des buveuses mondaines. Parallèlement, les recherches démontrent que l'abstinence diminue lorsque la proporion de salariées augmente (Hammer & Vaglum, 1989; Ebi-Kryston, Higgins & Keller, 1990). Cela signifie que les salariées boivent des quantités d'alcool considérablement plus élevées que les femmes au foyer. En outre, un grand nombre de salariées présentent au moins un problème lié à leur consommation d'alcool (Liban & Smart, 1980; Groupe de travail de la statistique sur l'alcool, 1984; Celentano & McQueen, 1984). Il s'agit d'un consensus qui se dégage des enquêtes nationales, régionales ou urbaines.

L'ENAAD, quant à elle, confirme partiellement ces résultats puisque les chômeuses comptent un nombre légèrement plus élevé de buveuses actuelles que les salariées. Mais, à l'instar des autres pays, on constate que les salariées se démarquent nettement des chômeuses et des femmes au foyer pour ce qui est du nombre moyen de verres d'alcool consommés par semaine (Figure 1).

La documentation nous a d'ailleurs permis de formuler quatre explications principales à ce phénomène : 1) le travail expose les femmes à de nouvelles normes de consommation; 2) le travail suscite une indépendance financière permettant une plus grande liberté de choix en matière d'alcool; 3) des changements dans les normes et les attitudes sociales ont fait de la consommation d'alcool chez les femmes un comportement à la mode, acceptable et approuvé socialement; 4) les salariées favoriseraient l'alcool comme stratégie de gestion du stress (Temple, 1987).

Figure 1
Nombre moyen de verres consommés par semaine selon le statut d'emploi des salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans, Canada, 1989



D'autre part, il faut préciser qu'il est difficile de ramener exclusivement les résultats aux femmes salariées parce que les travaux de la plupart des études épidémiologiques portent sur l'ensemble des femmes. Néanmoins, certains travaux donnent un aperçu de l'importance quan-

titative de la consommation d'alcool chez les salariées. Les données de prévalence proviennent de deux types d'échantillon : employées de milieux de travail variés, employées de professions précises. Par exemple, lors d'une enquête menée auprès de 1 932 hommes et 994 femmes, Volicer, Cahill et Smith (1981) tentent d'évaluer le pourcentage de buveurs à problème chez les hommes et les femmes. À l'aide de la Version abrégée du test de dépistage d'alcoolodépendance du Michigan et l'échelle quantité-fréquence de Mulford, les auteures rapportent que 4 p. 100 et 7,5 p. 100 respectivement des femmes sont des buveuses à problème. Une étude semblable réalisée par les mêmes auteures au sujet d'autres types d'emplois des secteurs privé et public indique que les estimations de consommation problématique sont de l'ordre de 9,2 p. 100 à 17,5 p. 100 chez les femmes. Une autre étude menée par Reichman (1983) qui avait pour but de planifier les services confirme ces résultats. En effet, plus de 10 p. 100 des femmes de cette étude avaient besoin d'aide pour gérer leur consommation d'alcool.

Les résultats d'études sur des catégories particulières d'emploi indiquent des niveaux comparables de consommation problématique. Par exemple, lors de l'examen du niveau de consommation de 247 cadres et professionnels d'une ville américaine, Shore (1985) estime que 10,9 p. 100 des femmes étaient des buveuses excessives selon une échelle de quantité-fréquence. Notons que, quelle que soit la nature de l'enquête, du milieu de travail (privé ou public), ou de l'instrument de mesure utilisé, on évalue à environ 8 p. 100 les salariées qui éprouvent un problème d'usage abusif d'alcool.

Par ailleurs, certaines études révèlent que les chômeuses et les femmes à la recherche d'un emploi rapportent plus de problèmes liés à leur consommation d'alcool que les salariées, qu'elles travaillent à temps plein ou à temps partiel (Wilsnack, Wilsnack & Klassen, 1984; Whitehead & Layne, 1987). À cet égard, l'analyse de l'ENAAD reste muette.

Selon la documentation scientifique, dans la catégorie des salariées, ce sont les jeunes femmes qui, aujourd'hui, consomment le plus d'alcool. En effet, leur niveau de consommation serait semblable à celui des jeunes travailleurs (Whitehead & Layne, 1987; Fillmore, 1984). À cet égard, les résultats de l'enquête canadienne diffèrent quelque peu. Ainsi, la proportion la plus élevée de buveuses actuelles se trouve chez les salariées et les chômeuses de 35 à 44 ans; et ce sont les femmes de 45 à 54 ans qui consomment le nombre moyen le plus élevé de verres par semaine.

On pourrait attribuer la différence des résultats au fait que les études ne se penchent pas toutes sur les mêmes facteurs. En effet, dans les premières études, on examine la quantité d'alcool consommé dans une semaine alors que l'ENAAD rapporte le nombre moyen de verres bus par semaine (Tableau 1).

La documentation rapporte que les femmes séparées ou divorcées seraient également moins souvent abstinentes que les femmes d'autres états civils; elles auraient plutôt tendance à boire à des niveaux plus élevés (Martin & Casswell, 1988; Celentano & McQueen, 1984). Il ressort également des données canadiennes et américaines que les femmes les plus scolarisées et celles qui ont un revenu élevé boivent plus souvent qu'elles ne sont abstinentes (Roy, 1984; Groupe de travail de la statistique sur l'alcool, 1984; Herd, 1988). L'ENAAD donne, quant à elle, des renseignements sur le nombre de verres consommés dans une semaine. Selon cette enquête, les femmes les plus scolarisées et celles dont le revenu est de 40 000 $ et plus consomment le nombre moyen le plus élevé de verres par semaine (Figures 2 et 3).

Tableau 1

Type de buveuses et nombre moyen de verres consommés chez les buveuses salariées et chômeuses âgées de 20 à 64 ans, au cours de la semaine qui a précédé l'enquête, selon l'âge, Canada, 1989

Âge	Estimation de la population (en milliers)	Abstinentes		Buveuses actuelles	Nombre de verres au cours des sept jours qui ont précédé l'enquête						Nombre moyen de verres par semaine
		Jamais bu	Anciennes buveuses		0	1-7	8-14	14-21	22-27	28 +	
20 - 24	651	* 2,8	13,3	83,9	61,0	31,6	* 5,6	-	-	-	2,71
25 - 34	1 566	6,0	10,7	83,3	59,4	35,0	4,3	* 1,0	-	-	2,13
35 - 44	1 424	4,2	10,0	85,8	59,7	34,2	* 4,6	-	-	-	2,20
45 - 54	809	* 6,2	18,3	75,5	59,4	32,9	* 4,1	-	-	-	3,04
55 - 64	421	* 7,0	19,4	73,6	62,4	21,0	* 5,0	-	-	-	2,08

* Forte variabilité de l'échantillonnage
\- Données supprimées
Source : SBSC, Enquête nationale sur l'alcool et les autres drogues, Canada, 1989

Figure 2

Nombre moyen de verres par semaine chez les salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans, selon la scolarité, Canada, 1989

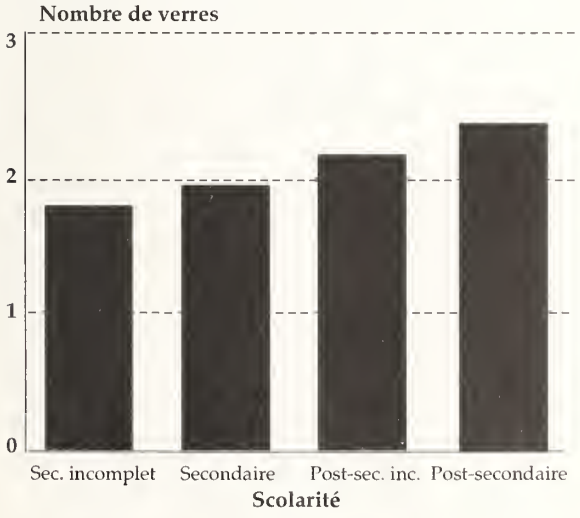
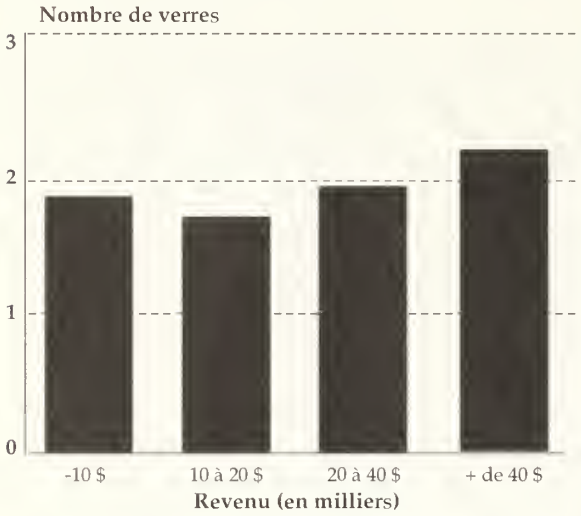


Figure 3

Nombre moyen de verres par semaine chez les salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans, selon le revenu, Canada, 1989



Pour ce qui est des catégories d'emploi, on observe que les femmes qui occupent des postes professionnels et cadres forment un groupe important de buveuses régulières et excessives (Groupe de travail de la statistique sur l'alcool, 1984; Celentano & McQueen, 1984). L'ENAAD donne aussi des renseignements semblables. En effet, chez les salariées, ce sont les cadres et les professionnelles qui comptent le plus de buveuses actuelles. Par contre, les cols bleus consomment autant de verres en moyenne par semaine (Tableau 2).

Tableau 2

Type de buveuses et nombre moyen de verres consommés chez les buveuses salariées, chômeuses et femmes au foyer actuelles âgées de 20 à 64 ans, au cours de la semaine qui a précédé l'enquête, selon la catégorie d'emploi, Canada, 1989

Catégorie d'emploi	Estimation de la population (en milliers)	Abstinentes		Buveuses actuelles	Nombre moyen de verres par semaine
		Jamais bu	Anciennes buveuses		
Cadre et profess.	1 876	4,2	9,8	86,0	2,67
Autres cols blancs	2 351	5,4	13,5	81,1	2,17
Cols bleus	477	* 7,3	21,2	71,5	2,69

* Forte variabilité de l'échantillonnage
\- Données supprimées
Source : SBSC, Enquête nationale sur l'alcool et les autres drogues, Canada, 1989

À cet égard, il n'existe aucune preuve à l'effet que les femmes qui occupent des postes professionnels ou cadres du milieu des affaires, milieu traditionnellement masculin, aient plus tendance à consommer de manière abusive ou non que les femmes dans des professions liées à la santé mentale, au nursing ou à l'enseignement. En effet, la totalité des enquêtes nationales ne vérifient pas l'hypothèse selon laquelle les femmes qui occupent des emplois traditionnellement réservés aux hommes imitent le comportement de ces derniers en matière de consommation d'alcool (Lennon, 1987). Des études menées auprès de groupes professionnels particuliers font ressortir l'importance de l'alcoolisation des femmes dans les emplois leur étant traditionnellement réservés. Par exemple, Watts et Short (1990) démontrent que, au cours de l'année écoulée, les enseignants (hommes et femmes) ont fait un usage plus élevé d'alcool, d'amphétamines et de tranquillisants que la population en général. De nombreux articles-synthèses, ouvrages ou recherches empiriques discutent également de l'usage abusif d'alcool chez les infirmières (Sullivan, 1987; Alcohol Research Group, 1990; Gaspin, 1986; Haack & Hughes, 1989). Il est intéressant de comparer ici les habitudes de consommation d'alcool des femmes évoluant dans des milieux de travail non traditionnels avec les habitudes de leurs collègues masculins :

- détresse typique en fonction du sexe : les femmes se sentent déprimées et les hommes boivent. Cependant, les femmes qui perçoivent leur rôle sexuel de façon moins traditionnelle adopteraient également des formes moins traditionnelles de détresse ou d'expression de leur psychopathologie (Lennon, 1987);
- l'accès à des postes traditionnellement réservés aux hommes équivaudrait à permettre aux femmes d'accéder au pouvoir et à l'alcool comme symbole de l'égalité des sexes (Morrissey, 1986);
- au contraire des hommes, les femmes qui évoluent dans ces milieux non traditionnels sont dépourvues de pairs auxquelles elles pourraient s'identifier (Collins, 1990). Cela explique le fait que l'alcool devient un substitut à certaines formes d'appui professionnel.

Données sur les médicaments psychotropes

Une autre tendance générale se démarque de façon très claire. Les femmes consomment des médicaments psychotropes plus fréquemment que les hommes; cette prédominance universelle se poursuivrait en dépit des campagnes de sensibilisation aux risques de dépendance découlant de l'usage prolongé de ces produits (Balter, Manheimer, Mellinger & Valenhuth, 1984; Laurier, Dumas, Grégoire & Duval, 1990). Selon Balter et al., les taux de consommation de médicaments psychotropes dans 11 pays (États-Unis et 10 pays de l'Europe de l'Ouest) varient entre 17,6 p. 100 et 7,4 p. 100 et le modèle prédominant serait une consommation quotidienne pendant au moins trois mois. Bien que très peu d'études illustrent les variations quantitatives de l'usage de ces produits chez les femmes par catégorie d'emploi, il ressort, à la lecture de plusieurs articles, que l'âge est directement proportionnel à l'usage des médicaments psychotropes (Riska & Klaukka, 1984; Pihl, Murdoch, Lapp & Marinier, 1986). Ainsi, un grand nombre de femmes au foyer âgées seraient classées dans cette catégorie. Par contre, l'étude de Zadoroznyj et Svarstad (1990) effectuée auprès d'une population du Wisconsin, comptant 46 p. 100 de femmes (64 p. 100 travaillaient), indique que les femmes qui travaillent ont exactement

les mêmes chances de faire usage de médicaments sur ordonnance que les femmes sans emploi. Une autre enquête, effectuée dans l'État de New-York, indique que les salariées célibataires âgées de 18 à 34 ans consomment plus de médicaments psychotropes sur ordonnance que les femmes au foyer âgées de 35 ans et plus (45 p. 100 contre 33 p. 100) (Kaestner, Frank, Marel & Schmeidler, 1986). De même, De Hart (1990) est d'avis que si l'on tient compte de la quantité de médicaments consommés par les femmes et les hommes, il est raisonnable de croire qu'un nombre substantiel de salariés (hommes et femmes) en consomment à un rythme qui entrave leur rendement professionnel.

À cet égard, l'ENAAD illustre les mêmes tendances. La première tendance veut que la proportion des femmes qui font usage de médicaments s'élève à mesure que celles-ci vieillissent; la deuxième tendance veut qu'un plus grand nombre de femmes au foyer ont consommé des tranquillisants, des somnifères et des anti-dépresseurs au cours du mois qui a précédé l'enquête.

Par contre, les salariées déclarent en plus grand nombre avoir consommé de la codéine, du démérol et de la morphine durant cette période (Tableau 3). Globalement, le profil sociodémographique des femmes qui font usage de tranquillisants et de somnifères se limiterait aux femmes ayant une faible scolarité (Figure 4), aux femmes dont le revenu est de moins de 10 000 $ (Figure 5) et aux femmes qui ont déjà été mariées (veuves, divorcées et séparées) (Figure 6).

Tableau 3

Pourcentage des salariées et des femmes au foyer âgées de 20 à 64 ans qui ont consommé certaines drogues légales au cours du mois qui a précédé l'enquête, Canada, 1989

	Estimation de la population (en milliers)	Somnifères	Tranquillisants	Pilules amaigrissantes, stimulants	Anti-dépresseurs	Codéine, démérol, morphine
Salariées	4 696	2,2	2,9	1,7*	1,8	6,1
Femmes au foyer	2 225	4,1	6,7	-	3,7	5,8

* Forte variabilité de l'échantillonnage
- Données supprimées
Source : SBSC, Enquête nationale sur l'alcool et les autres drogues, Canada, 1989

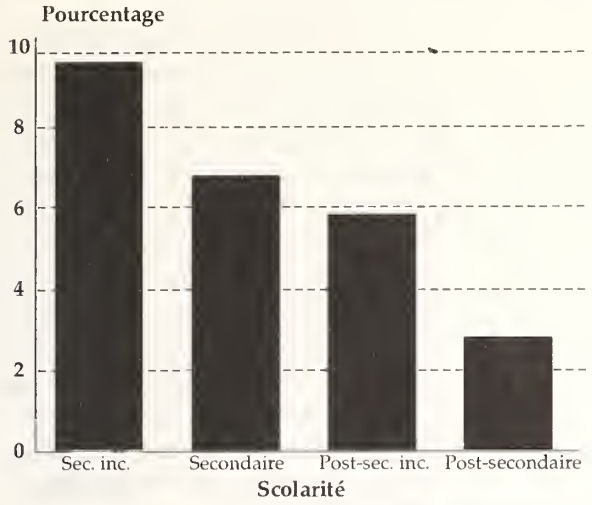


Figure 4
Pourcentage des salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans qui ont consommé des tranquillisants et somnifères au cours du mois qui a précédé l'enquête, selon la scolarité, Canada, 1989

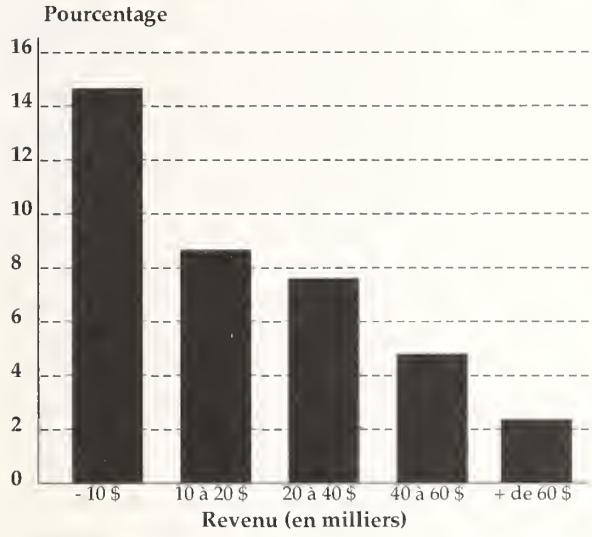


Figure 5
Pourcentage des salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans qui ont consommé des tranquillisants et somnifères au cours du mois qui a précédé l'enquête, selon le revenu, Canada, 1989

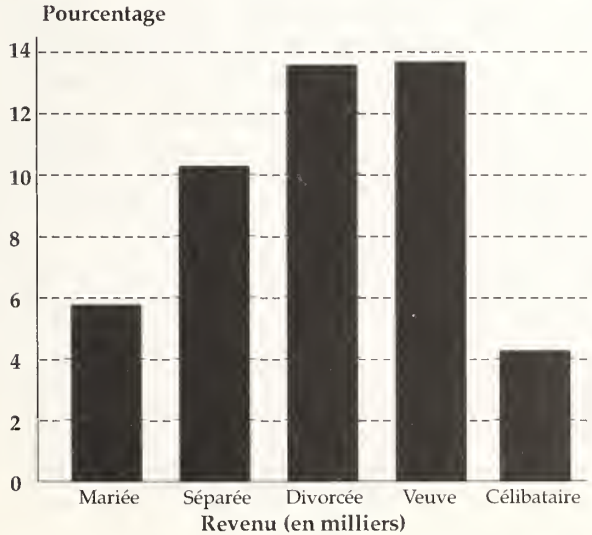


Figure 6
Pourcentage des salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans qui ont consommé des tranquillisants et somnifères au cours du mois qui a précédé l'enquête, selon l'état civil, Canada, 1989

Données sur le tabac

Les articles consultés font ressortir que les femmes, particulièrement les jeunes femmes, sont toujours attirées par le tabac, et ce, même si le tabagisme perd nettement du terrain dans plusieurs pays (Ernster, 1986; Guyon 1990). Par exemple, lorsqu'on se penche sur les résultats de l'Enquête Santé Québec (Rapport Santé Québec, 1988) et qu'on les compare avec les résultats de l'Enquête Santé Canada (1978-1979), on remarque que la proportion des fumeurs réguliers est considérablement réduite, passant de 45 p. 100 à 33 p. 100. Cependant, parmi les femmes âgées de 25 à 29 ans, la proportion est toujours de 49 p. 100. Nous avons aussi relevé que c'est au sein du groupe des 25 à 44 ans que l'on retrouve le plus de fumeurs quotidiens (Rapport Santé Québec, 1988). L'ENAAD révèle aussi que les jeunes femmes comptent le pourcentage le plus élevé de fumeuses actuelles; elles sont également plus nombreuses à avoir fumé de 1 à 10 et de 11 à 25 cigarettes par jour au cours de la semaine qui a précédé l'enquête (Tableau 4).

La documentation scientifique nous apprend également que les femmes qui occupent des postes de direction sont parmi les plus grandes fumeuses (Guyon, 1990). De plus, l'usage de la cigarette est plus répandu chez les chômeuses et les cols bleus (Sterling & Weinkam, 1990; Guyon, 1990). Malheureusement, l'ENAAD demeure muette à ce sujet.

Les femmes imitent donc le comportement des hommes en matière de tabagisme. Cette tendance apparaît aussi dans les pays en voie de développement. L'étude de Skander et Larbaoui (1989) effectuée auprès de la population du département d'Alger précise que de plus en plus d'Algériennes fument (13,6 p. 100 dans le cadre de l'étude). Les fumeuses sont salariées (cadres ou professionnelles) alors que les ouvrières et les femmes au foyer n'ont jamais fumé.

Données sur les drogues illégales

Bien que la consommation de drogues illégales soit plus faible chez les femmes que chez les hommes (Enquête Santé Québec, 1987), il semble qu'un certain nombre de salariées (cadres d'entreprises ou professionnelles ayant de grosses responsabilités) reçoivent de la cocaïne des hommes comme d'autres reçoivent des fleurs ou des chocolats. Du moins, c'est ce que révèle l'étude de Washton (1986) effectuée auprès de femmes qui

Tableau 4

Type de fumeuses et nombre de cigarettes fumées en moyenne par jour par les fumeuses actuelles salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans au cours de la semaine qui a précédé l'enquête, selon le groupe d'âge, Canada, 1989

Groupe d'âge	Estimation de la population (en milliers)	Non-fumeuses		Fumeuses actuelles	Nombre de cigarettes fumées par jour au cours de la semaine qui a précédé l'enquête			
		Jamais fumé	Ancienne fumeuse		0	1 - 10	11 - 25	26 et +
20 - 24	1 007	44,2	8,0	37,8	-	12,6	23,9	1,2
25 - 34	2 352	42,1	21,8	36,1	1,2	10,0	23,0	1,8
35 - 44	1 991	40,3	26,2	33,5	0,9	8,2	22,0	1,3
45 - 54	1 352	43,2	23,6	33,2	2,3	7,4	19,8	3,6
55 - 64	1 192	48,0	23,0	29,0	-	8,1	19,1	-

* Forte variabilité d'échantillonnage
- Données supprimées

Source : SBSC, Enquête nationale sur l'alcool et les autres drogues, Canada, 1989

ont fait appel à la ligne d'information téléphonique 800-Cocaïne. De ces femmes, 67 p. 100 rapportent avoir reçu la cocaïne en cadeau des hommes. Cette étude démontre également que 76 p. 100 des femmes faisaient usage d'autres drogues ou buvaient de manière abusive pour réduire leur consommation de cocaïne. Une autre étude épidémiologique illustre également le fait que chez les femmes célibataires âgées de 18 à 34 ans qui travaillent à temps plein, l'usage de drogues psychotropes illégales comme la cocaïne, la marijuana, les stimulants est quatre fois plus élevé que chez les femmes au foyer du même âge (32 p. 100 contre 9 p. 100) (Kaestner, Frank, Marel & Schmeidler, 1986). Toutefois, les études menées auprès de populations institutionnelles illustrent une autre tendance. Par exemple, les travaux de Moreau (1987) indiquent que les chômeuses constituent la catégorie socioprofessionnelle la plus importante parmi les consommatrices de drogues illégales. Dans le cadre de cette étude, l'héroïne était la substance la plus consommée. On pourrait sans doute expliquer ces résultats contradictoires avec les caractéristiques des populations étudiées.

Selon les données de l'ENAAD, environ 2 p. 100 des salariées et des chômeuses réunies ont consommé de la cocaïne ou du crack à un moment ou un autre de leur vie. Un pourcentage plus élevé de salariées et de chômeuses réunies ont aussi déclaré avoir consommé de la marijuana ou du haschich à un moment ou un autre de leur vie (Tableau 5).

Enfin, la documentation révèle que les femmes ont plus tendance que les hommes à faire usage de tranquillisants et de sédatifs lorsqu'elles consomment de l'alcool. Selon une étude menée auprès d'une population institutionnelle, les salariées et les femmes au foyer adopteraient sensiblement les mêmes pratiques (Moreau, 1987). De plus, l'Enquête Santé Québec (Rapport Santé Québec, 1988) nous apprend que 35 p. 100 de la population fait un usage concomitant d'alcool et de tranquillisants, et que la prévalence des usagers de tranquillisants qui sont également de gros buveurs est deux fois plus élevée chez les femmes (Guyon, 1990). Il ressort également de la documentation axée sur le milieu hospitalier que cette pratique s'avère courante chez les infirmières (Sullivan, 1987; Finley, 1982; Booth & Gillard, 1981).

Les recherches confirment aussi que les femmes font un usage simultané d'autres substances. Par exemple, plusieurs études démontrent que les buveuses sont aussi des fumeuses (Mello, Mendelson & Palmieri, 1987; Beckwith, 1986). D'autres

Tableau 5

Pourcentage des salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans qui ont consommé des drogues illégales dans les 12 mois qui ont précédé l'enquête, Canada, 1989

	Estimation de la population (en milliers)	Marijuana ou haschich		Cocaïne ou crack		LSD, speed ou héroïne	
		À un moment ou un autre de leur vie	L'an dernier	À un moment ou un autre de leur vie	L'an dernier	À un moment ou un autre de leur vie	L'an dernier
Salariées et chômeuses	4 872	15,4	4,7	2,2	-	1,2	-
Femmes au foyer	2 225	9,5	* 1,4	* 2,0	-	* 1,7	-

* Forte variabilité de l'échantillonnage
- Données supprimées

Source : SBSC, Enquête nationale sur l'alcool et les autres drogues, Canada, 1989

études encore associent l'usage d'alcool des usagères de marijuana à certaines périodes du cycle menstruel (Griffin, Mello, Mendelson & Lex, 1987).

Portrait des consommatrices

D'autres scientifiques classent les consommatrices de diverses catégories d'emploi selon des typologies. Celles-ci permettent de faire connaisance avec les sous-groupes de consommatrices en fonction de variables autres que socio-démographiques classiques.

Dans le cadre d'une étude qualitative réalisée exclusivement auprès de salariées, à partir du niveau de stress ressenti par ces femmes au moment où elles ont intensifié leur consommation d'alcool, Morissette (1990) a cerné trois types de consommatrices d'alcool à risque. Le premier type comporte des femmes en état de crise transitionnelle ou événementielle, c'est-à-dire qu'elles se trouvent dans un état de détresse engendré par l'entrée sur le marché du travail ou le moment de la pré-retraite, par des événements sociofamiliaux (p. ex., avortement) ou socioprofessionnels (p. ex., démotion). Le deuxième type comporte des femmes déçues par leur quotidien professionnel, celles qui vivent des problèmes qui entravent leur quotidien (p. ex., problème avec le supérieur immédiat). Le troisième type comporte des femmes tournées vers la vie sociale, c'est-à-dire qu'elles ont un goût marqué pour le plaisir et leur niveau de stress au travail est relativement bas. Il semble que, d'un certain point de vue, ce troisième type soit tout à fait opposé aux précédents en ce sens qu'il touche les femmes orientées vers les activités sociales plutôt que vers le travail.

Berthelot, Clément, Drulhe, Forne et Membrado (1984) ont également esquissé une typologie mais, cette fois, il s'agit de femmes alcooliques de divers statuts d'emploi. Ce sont :

- des exclues de la modernité : des femmes qui subissent leur destin. Dans ce groupe on retrouve principalement des femmes qui ont arrêté de travailler;
- des déchirées : des femmes en contradiction permanente. Ici émergent celles qui sont retournées sur le marché du travail;
- des emmaisonnées : des femmes malades de leur choix. La totalité d'entre elles sont des femmes au foyer;
- des modernistes : des femmes déçues d'une modernité qu'elles croyaient meilleure. Dans ce groupe on retrouve principalement des femmes seules célibataires ou divorcées; elles ont un emploi et n'ont jamais arrêté de travailler.

Dans une recherche ayant pour but de comprendre la signification de l'usage à long terme (au moins 6 mois) de médicaments psychotropes, Helman (1981) classifie les usagers chroniques en trois groupes distincts : un premier groupe pour qui la consommation est «tonique»; il regroupe les personnes qui contrôlent elles-mêmes le dosage et le moment de la prise des médicaments; un second groupe pour qui la consommation est «carburant»; il regroupe des personnes ayant un contrôle variable sur leur consommation, mais pour qui consommer est une habitude pouvant être psychologique; un troisième groupe pour qui les drogues sur ordonnance sont «nourriture»; il s'agit de patients qui, sans leurs médicaments, ne pourraient vivre indépendamment de leur entourage. Ici les sujets de l'étude sont des hommes et des femmes de diverses catégories d'emploi et d'états civils et parentaux.

Enfin, Cafferata, Kasper et Bernstein décrivent le portrait-robot de la femme qui a toutes les chances de se faire prescrire un psychotrope : «il s'agit

d'une femme sans conjoint et sans enfant de moins de six ans si elle travaille à l'extérieur, ou d'une femme avec de jeunes enfants mais qui ne serait pas sur le marché du travail» (tiré de Guyon, 1990, p.63).

Les motifs de consommation

Lorsque l'on étudie les motifs qui poussent les femmes à consommer, un point essentiel se dégage : la ressemblance des motifs de consommation lorsqu'on les examine en fonction de la substance consommée.

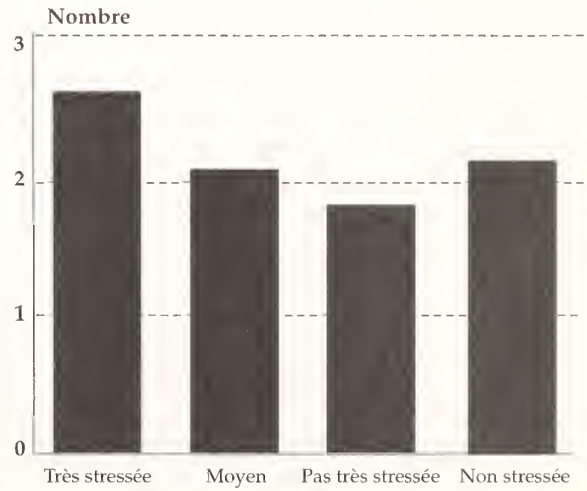
Dans l'étude de Washton (1986) citée auparavant, les femmes du milieu des affaires et les professionnelles disaient faire usage de cocaïne pour avoir plus d'énergie, pour réduire le stress, pour diminuer leur appétit ou mieux performer sexuellement. Dans l'étude de Helman (1981), les hommes et les femmes de diverses catégories d'emploi consomment les tranquillisants durant la journée pour se calmer ou réduire le stress. Dans l'étude québécoise de Pihl, Murdoch, Lapp et Marinier (1986) réalisée auprès de Montréalaises, l'usage de psychotropes chez les femmes était associé au désir d'oublier les soucis, le stress et la dépression. Les infirmières qui ont participé à l'étude de Sullivan (1987) rapportent avoir commencé à prendre de l'alcool ou divers types de drogues pour se détendre, pour l'essayer avec des amis ou pour soulager la douleur.

D'après la documentation, les salariées semblent vivre des situations stressantes qu'elles s'empressent de noyer dans l'alcool. En effet, plus de 52 p. 100 des infirmières qui ont participé à l'étude de Sullivan (1987) répondent que le stress professionnel contribue à leur problème d'usage abusif. La consommation dite échappatoire se situe entre 20 p. 100 et 30 p. 100 de toutes les catégories professionnelles (professionnelles, employées de bureau et de service) dans l'étude de Celentano & McQueen (1984). Les consommatrices d'alcool à risque de Morissette (1990) (enseignantes, infirmières, bibliothécaires, avocates, cadres, etc.) disent avoir accru leur consommation pour composer avec un événement socio-professionnel ou affronter leur quotidien professionnel.

Les résultats généraux de l'ENAAD mettent également en évidence l'élément stress en rapport avec la consommation d'alcool des femmes. Les femmes qui se disent le plus stressées dans cette enquête sont aussi celles qui ont déclaré avoir consommé le nombre moyen le plus élevé de verres d'alcool par semaine (Figure 7).

Figure 7

Nombre moyen de verres consommés par semaine chez les salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans au cours de la semaine qui a précédé l'enquête, selon le niveau de stress, Canada, 1989



Le choix d'une drogue

La façon dont les femmes choisissent une drogue plutôt qu'une autre est un thème rarement abordé directement dans la documentation scientifique. Quand on l'aborde, c'est par le biais de l'influence exercée par l'entourage et les médias. Nous aborderons ce sujet plus loin dans le présent chapitre.

L'influence du partenaire

L'influence du partenaire est l'un des thèmes les plus fréquemment abordés dans le cadre de l'alcoolisation des femmes. Selon la documentation, cette influence semble tout aussi actuelle que dans les années 1950, et ce, en dépit des changements sociologiques qui ont marqué la vie des femmes depuis 20 ans. En effet, à l'instar de la consommatrice d'alcool des enquêtes récentes, la femme alcoolique en traitement dont parlaient les études des années 1950 semble être clairement attirée par un conjoint alcoolique (Lisansky, 1957), peu importe la catégorie d'emploi. Par ailleurs, des enquêtes menées à l'échelle nationale et locale aux États-Unis ont démontré que les femmes qui consommaient de l'alcool dans un cadre social ou qui souffraient de problèmes liés à leur consommation ont un conjoint ou un ami considéré comme buveur régulier ou à problème (Wilsnack, Wilsnack & Klassen, 1984; Celentano & McQueen, 1984). Dans le cadre d'une étude ayant pour but d'examiner l'importance relative de certains facteurs comme l'accessibilité et le stress, l'élément le plus étroitement lié à la consommation d'alcool des femmes (Hammer & Vaglum, 1989) était la consommation du conjoint.

Ces observations posent le problème du type d'influence et du moment où le comportement alcoolique du conjoint entre en jeu. L'hypothèse de la pression à boire à tous moments est évidemment soulevée (Wilsnack, Wilsnack & Klassen, 1984). Mais les recherches ne cernent pas encore très bien cette question.

Aux yeux de certains épidémiologistes, le partenaire pourrait jouer un rôle précis dans l'alcoolisation des femmes, comme l'initier à l'alcool et l'aider ou l'encourager à boire (Wilsnack, Wilsnack & Klassen, 1986). Par ailleurs, Morissette (1990) met aussi en lumière l'influence du partenaire chez les salariées. En effet, les femmes qui ont participé à cette étude déclarent avoir commencé à boire dans un cadre social ou ont appris à boire de façon régulière avec leur partenaire. Elles ont en outre déclaré avoir développé un goût pour certains spiritueux ou s'être habituées, sous l'influence de leur partenaire, à garder une réserve d'alcool à la maison. À cet égard, l'ENAAD révèle que le tiers des femmes salariées, chômeuses et femmes au foyer consomment quand elles sont invitées à le faire par leur partenaire (Tableau 6).

Tableau 6

Pourcentage des salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans qui ont consommé de l'alcool parce qu'elles étaient invitées à le faire par une autre personne, Canada, 1989

* Forte variabilité de l'échantillonnage
\- Données supprimées
Source : SBSC, Enquête nationale sur l'alcool et les autres drogues, Canada, 1989

	Estimation de la population (en milliers)	Conjoint ou partenaire	Membre de la famille	Ami	Collègue
Salariées et chômeuses	4 872	35,7	48,7	58,6	32,6
Femmes au foyer	2 225	33,4	36,7	38,2	4,4

L'influence parentale

Un deuxième thème largement abordé est celui de l'influence parentale. Premièrement, il ressort que les hommes et les femmes en traitement ont plus souvent des antécédents familiaux d'usage abusif d'alcool que la population en général; deuxièmement, l'usage abusif d'alcool est plus souvent présent dans la famille de la femme alcoolique que dans celle de l'homme alcoolique (Cotton, 1979; Gomberg, 1978). L'influence parentale se fait aussi sentir chez les salariées, peu importe l'échantillon. En effet, les chercheuses Volicer, Cahill, Neuburger et Arntz (1983) signalent que la seule différence notoire entre les salariées aux prises avec une consommation problématique et les autres femmes qui participaient à leur étude est la présence d'une consommation abusive dans la famille, surtout chez les parents. Cette caractéristique familiale est aussi relevée par Sullivan (1987) dans un échantillon à l'échelle nationale d'infirmières qui reconnaissent avoir un problème d'usage abusif de drogues. Parker, Parker, Harford et Farmer (1987) en font aussi mention dans un échantillon représentatif d'hommes et de femmes salariées habitant Détroit. L'étude de Morissette (1990) a permis de constater que l'influence parentale agit de plusieurs façons : 1) au sein de la culture familiale, les femmes prendraient connaissance de l'efficacité du produit à l'intérieur même de la famille; 2) certaines auraient tendance à adopter les mêmes habitudes de consommation que leurs parents et auraient tendance à intensifier leur consommation dans les mêmes circonstances; 3) d'autres adopteraient l'alcool pour les mêmes motifs que leurs parents tout en établissant les mêmes limites envers le produit; 4) certaines autres encore auraient le même rituel de consommation qu'un parent (p. ex., prendre l'apéro). Cela illustre bien comment les salariées ont une expérience d'alcoolisation à l'image de celle d'un parent. Aucune des questions de l'enquête ne portait sur ce thème.

L'influence des pairs

La documentation scientifique se penche plus rarement sur l'influence des pairs sur l'alcoolisation des femmes comparativement à l'influence des pairs sur celle des hommes. Notons toutefois que l'influence des amis sur la consommation d'alcool des jeunes femmes semble mieux démontrée (Sandmaier, 1980). Par ailleurs, la consommation en groupe à la taverne a depuis longtemps joué un rôle social important chez certains groupes de travailleurs dont les mineurs, les ouvriers d'usines et les ouvriers du bâtiment (Plant, 1981). Plusieurs auteurs discutent des normes du réseau professionnel en rapport avec la consommation des hommes (Herold & Conlon, 1981; Seeman, Seeman & Budros, 1988). Par contre, la thèse de l'adhésion des salariées à un modèle de consommation d'alcool masculin (dans ce cas-ci boire avec les collègues de travail) ne semble pas encore confirmée. Alors qu'elle tentait de déceler de nouvelles formes d'alcoolisation chez les salariées, Morissette (1990) n'a pas relevé de consommation systématisée le vendredi soir ou le vendredi midi chez les femmes qui participaient à son étude. Seules quelques femmes de groupes d'âges variés se regroupaient avec des collègues pour se récompenser de leur semaine de travail. Dans ce cas, il s'agissait d'une consommation bien circonscrite en ce qui concerne la quantité d'alcool consommé et le temps passé ensemble. L'enquête de Morissette (1993) portant sur des professionnelles et des cols blancs de la région de Montréal révèle aussi que peu de femmes consomment avec leurs collègues de travail.

La publicité

La publicité aurait aussi un effet sur l'intensité de la consommation (Atkin & Block, 1985); de plus, elle influerait sur le choix du produit. Deux études récentes mettent au jour les efforts déployés par l'industrie du tabac dans les magazines féminins pour rejoindre les femmes et ainsi accroître leurs ventes. (Altman, Slater, Albright & Macedby, 1987; Ernster, 1986). Ces études constatent que la publicité, sur le tabac comme sur l'alcool, trace le portrait de la femme parfaite. En effet, on y présente la plupart du temps une femme intelligente, ayant un emploi de prestige (identification non négligeable pour la salariée) et entourée d'hommes non moins intelligents; ou encore on y présente une femme mince, élégante, attrayante et détendue qui grille une cigarette.

Les pratiques de consommation : où, quand et comment boivent les femmes?

Les enquêtes effectuées auprès de salariés des deux sexes nous apprennent que les femmes boivent moins que les hommes (Parker, Parker, Brody & Schoenberg, 1984; Parker, Parker, Harford & Farmer, 1987; Blume 1986). Mais peut-on se fier à ces résultats? Blume (1986) fait une mise en garde intéressante au sujet de la consommation d'alcool plus faible des femmes. Elle déclare : «instead of a morning drink, she may have a morning valium; her nightcap may contain less alcohol and more sedative drugs» (Blume, 1986, p. 1 469). L'élément qui retient ici l'attention est le suivant : si les femmes boivent moins, c'est que leurs habitudes de consommation sont différentes de celles des hommes. Ces propos nous ramènent au phénomène de l'usage de drogues multiples chez les femmes.

Les rapports d'études québécoises révèlent que bien peu de femmes boivent tous les jours. Seul 2 p. 100 de la population féminine consomme tous les jours, selon l'Enquête Santé Québec (Rapport Santé Québec, 1988); 87 p. 100 des femmes consomment moins d'un verre par jour selon le rapport intitulé «Les changements dans la consommation d'alcool au Québec» (1990). Selon le même rapport, 2,4 p. 100 des femmes boivent 14 verres ou plus par semaine, 50 p. 100 boivent régulièrement (au moins un fois par mois), et 25 p. 100 sont des buveuses occasionnelles. On ignore malheureusement la répartition des buveuses par catégorie d'emploi. Morissette (1993) rapporte que 3,9 p. 100 des cols blancs de sexe féminin et des professionnelles de la région métropolitaine de Montréal consomment de l'alcool chaque jour et 7,1 p. 100 en consomment de quatre à six fois par semaine.

En ce qui a trait à la fréquence de la consommation, l'analyse des données du ENAAD indique que, selon le groupe d'âge, quatre pour cent des femmes âgées de 45 ans et plus ont consommé de l'alcool tous les jours au cours de la semaine qui a précédé l'enquête. (Tableau 7). Selon la catégorie d'emploi, environ 3 p. 100 des salariées ont consommé de quatre à six fois par semaine et 2 p. 100 ont rapporté avoir consommé chaque jour au cours de la même période (Tableau 8).

Tableau 7

Fréquence de la consommation des buveuses actuelles salariées, chômeuses et femmes au foyer âgées de 20 à 64 ans au cours de la semaine qui a précédé l'enquête, selon le groupe d'âge, Canada, 1989

* Forte variabilité de l'échantillonnage
- Données supprimées
Source : SBSC, Enquête nationale sur l'alcool et les autres drogues, Canada, 1989

Groupe d'âge	Estimation de la population (en milliers)	Moins de 1 fois par mois	1 à 3 fois par mois	1 fois par semaine	2 à 3 fois par semaine	4 à 6 fois par semaine	Chaque jour	Nombre moyen de verres par semaine
20 - 64	1 007	23,4	28,2	18,5	10,2	1,8	0,5	2,19
25 - 34	2 352	29,2	25,5	15,3	9,7	1,6	0,7	1,82
35 - 44	1 992	27,7	20,3	13,3	13,8	4,0	1,4	2,15
45 - 54	1 352	20,8	17,0	13,6	9,4	2,8	4,2	2,66
55 - 64	1 197	27,2	18,1	7,5	8,6	1,9	4,0	1,75

Tableau 8

Fréquence de la consommation des buveuses actuelles, salariées, chômeuses et femmes au foyer, âgées de 20 à 64 ans, au cours de la semaine qui a précédé l'enquête, selon la catégorie d'emploi, Canada, 1989

* Forte variabilité de l'échantillonnage
- Données supprimées
Source : SBSC, Enquête nationale sur l'alcool et les autres drogues, Canada, 1989

Catégorie d'emploi	Estimation de la population (en milliers)	Moins de 1 fois par mois	1 à 3 fois par mois	1 fois par semaine	2 à 3 fois par semaine	4 à 6 fois par semaine	Chaque jour	Nombre moyen de verres par semaine
Salariée	4 696	24,8	22,9	16,0	12,7	3,1	2,2	2,42
Chômeuse	177	32,1	28,7	* 15,6	* 8,6	-	-	0,89
Femme au foyer	2 225	29,5	18,0	9,7	7,1	* 1,8	* 1,2	1,46

Pour terminer le tour d'horizon sur la question des habitudes de consommation d'alcool des salariées, ajoutons que même si nous n'avons pas toutes les données en main, la documentation fournit certaines pistes permettant de mieux les cerner. Par exemple, des cadres recrutées dans un programme d'aide aux employés signalent boire à l'image des hommes dans le cadre de leurs activités professionnelles parce que la consommation d'alcool est tolérée par leur supérieur. On retrouve ici l'influence de l'absence de contrôle et de la culture administrative des milieu de bureau notés par Trice et Roman (1978) sur la consommation d'alcool des salariées. Par ailleurs, d'autres femmes jouissant de moins d'autonomie professionnelle rapportent boire le soir, les fins de semaine et après le travail (Kleeman & Googins, 1983). Dans cet ordre d'idée, Morissette (1990) illustre que les salariées de moins de 30 ans qui font une consommation d'alcool à risque imitent la con-

sommation des images publicitaires, c'est-à-dire une consommation publique de fin de semaine, une consommation mixte et une consommation de groupe tandis que les salariées âgées de plus de 30 ans consomment en privé et en semi-privé, en solitaires ou entre amis, et ce, exclusivement en dehors des heures de travail. En d'autres termes, ces salariées consomment à la maison comme le font les femmes au foyer (Gomberg, 1979). Dans l'étude de Martin et Casswell (1988) les buveuses qui fréquentent les boîtes de nuit sont âgées de 16 à 29 ans et de 35 à 44 ans; les plus jeunes sont célibataires et sans enfant et travaillent à temps plein; celles de plus de 35 ans sont mariées, ont des enfants et sont majoritairement sans emploi. Les buveuses solitaires (2 p. 100) sont âgées de plus de 45 ans, sont des femmes au foyer ou à la retraite, veuves, séparées ou divorcées.

Selon certains auteurs, pour comprendre les habitudes de consommation des salariées, il faut inévitablement tenir compte de la culture organisationnelle (Staudenmeir, 1987; Hammer & Vaglum, 1989), principalement des normes sociales et du type de supervision propres aux milieux de travail féminisés. Comme nous le savons déjà, dans les milieux traditionnellement réservés aux femmes, la majorité n'est ni autorisée, ni encouragée à boire durant ses activités professionnelles. De plus, les emplois dans ces «ghettos» (emploi de bureau, enseignement et soins, etc.) sont caractérisés par une supervision généralement étroite. En conséquence, il est plausible de croire que seuls certains sous-groupes de salariées auraient l'occasion de boire durant les heures de travail. À cet égard, on peut dire que d'une certaine manière, la culture organisationnelle des milieux de travail féminisés encourage une consommation privée d'alcool.

De plus, il faut tenir compte de la culture de chacun des emplois (Morissette, 1990), soit du cadre typique des emplois majoritairement occupés par les femmes, des pressions particulières des groupes, de la nature des tâches (enseigner ou soigner) ou de l'image que la société se fait de cet emploi. Il faut mentionner ici que, selon la croyance populaire, ces emplois sont encore largement imprégnés du don de soi et de l'altruisme, donc le mélange de l'alcool et du travail est contraire à l'éthique de ces professions; c'est perçu comme une conduite anti-professionnelle. En conséquence, la peur du stigmate et la conscience de s'écarter de l'image que l'on a de la «professionnelle» du milieu inhiberaient presque complètement toute manifestation d'alcoolisation dans le cadre de travail de certains emplois traditionnellement réservés aux femmes.

Soulignons aussi que certains éléments de la culture organisationnelle et de la culture des emplois pourraient aussi expliquer pourquoi les femmes qui font une consommation problématique d'alcool sont moins visibles que les hommes dans les milieux de travail et les programmes d'aide aux employés (PAE) (Morissette, 1986; Reichman, 1983; Solomon, 1983).

Enfin, certaines recherches cliniques mettant en relation le rôle de femme au foyer et l'usage d'alcool démontrent que les femmes qui font usage d'alcool semblent avoir des habitudes de consommation qui ne nuisent pas à leur rendement. En effet, des sujets participant à des études cliniques (Fort & Porterfield, 1961) rapportent terminer leurs tâches ménagères avant de commencer à boire. Les femmes déclarent boire une petite quantité d'alcool durant les tâches ménagères, c'est-à-dire une quantité suffisante pour changer leur réalité mais insuffisante pour les empêcher de fonctionner. Dès leur travail terminé, elles intensifient leur consommation. Signalons

que l'effet de l'alcool sur le rendement au travail des femmes au foyer n'a pas été plus rigoureusement analysé (Gomberg, 1976) ni plus récemment étudié.

Des facteurs de risque

L'insatisfaction dans les rôles sexuels

Globalement, les recherches menées récemment suggèrent que le rôle social joué par les femmes influence leur consommation d'alcool. Cela semble vrai dans le cas de l'usage d'alcool comme dans le cas de la dépendance à l'alcool, et ce, selon plusieurs rôles : fille ou conjointe d'un alcoolique (comme nous l'avons déjà vu), partenaire sexuelle (Beckman, 1980; Wilsnack, Wilsnack & Klassen, 1986), mère (Curlee, 1969), femme au foyer et salariée. Nous discuterons plus loin du courant de la recherche actuelle qui prône des explications de type psychosocial à la consommation d'alcool et met fin jusqu'à un certain point aux explications pathologiques comme les troubles de la personnalité et une certaine faiblesse des femmes en matière de consommation d'alcool.

Les résultats généraux relativement à la santé des femmes laissent entendre que l'absence de rôle peut avoir des répercussions graves sur leur santé (Thoits, 1983; Verbrugge, 1982b, 1983). Ainsi, Wilsnack et Cheloha (1987) maintiennent que les déficits (absence, perte ou carence) associés aux rôles de partenaire, de mère et de salariée sont des facteurs de risque déterminants dans l'apparition des problèmes d'usage abusif d'alcool chez les femmes. Les plus jeunes boivent pour combler une lacune sur le plan de l'identité; les femmes d'âge moyen le font pour soulager un sentiment de solitude, d'inutilité ou de regret envers l'irréversibilité d'un rôle et enfin, les plus âgées boivent pour oublier l'ennui, la frustration ou un sentiment d'impuissance à pouvoir jouer un rôle quelconque. Selon les auteures, les déficits intensifieraient la détresse psychologique, laquelle entraîne une hausse de la consommation d'alcool tandis que l'absence de rôle (p. ex., mère ou conjointe) donnerait plus d'occasions de boire ou de s'enivrer.

À l'instar de l'insatisfaction en ce qui a trait à son rôle, l'alcoolisation est reliée à une santé précaire chez les femmes (Verbrugge, 1986). Des recherches menées il y a plusieurs années et plus récemment ont permis de confirmer la relation entre l'insatisfaction face au rôle de femme au foyer et l'usage d'alcool. La nature de l'insatisfaction des femmes dans le rôle de femme au foyer n'est toutefois pas bien démontrée mais, on découvre quelques pistes menant à une explication. Des femmes au foyer ayant abandonné leur métier ressentiraient un isolement pénible découlant de l'absence d'activités professionnelles. D'autres femmes ayant connu les gratifications d'un emploi seraient insatisfaites de la routine que leur offre le ménage et l'éducation des enfants (Basquin & Osouf, 1965). L'insatisfaction des femmes au foyer pourrait également prendre sa source dans la frustration causée par le manque d'argent, le sentiment d'incompétence ou la sous-charge (Drutschel & Pettinati, 1989) ou encore le stress domestique (Gomberg, 1976). Finalement, Farid, Elsherbini, Ogden, Lucas & Williams (1989) ont comparé des femmes au foyer et des salariées qui faisaient toutes usage d'alcool. Leur étude révèle que les femmes au foyer sont les moins satisfaites de leur rôle. Soulignons toutefois que les recherches en matière d'insatisfaction professionnelle des femmes sont rares.

Le stress au travail

Des études corrélationnelles suggèrent que certaines dimensions créatrices de stress d'un emploi peuvent contribuer à l'apparition d'une consommation problématique d'alcool. Cependant, ces études ne donnent ni preuve formelle d'une étiologie professionnelle, ni détails sur les situations créatrices de stress suscitant une consommation d'alcool chez les femmes. Ces études portent généralement sur l'ensemble de la population active (hommes et femmes) et sont effectuées auprès de trois types d'échantillon : des échantillons comptant des salariés à l'échelle nationale et urbaine et dans des milieux de travail précis. À titre d'exemple, voici les résultats de quelques-unes de ces études. Fennell, Rodin et Kantor (1981-82) mettent au jour une relation entre le stress perçu et les attitudes des salariés à l'égard de l'alcool (boire pour se détendre, pour oublier les ennuis professionnels et les problèmes. Mangione et Quinn (1975) reconnaissent un lien entre la satisfaction au travail et la consommation de drogues incluant l'alcool. Hingston, Mangione et Barrett (1981) démontrent que l'ennui professionnel est associé à une consommation d'alcool des salariés de Boston. Enfin, Parker et Farmer (1988) ont découvert que des caractéristiques créatrices de stress comme les pressions ou les responsabilités professionnelles augmentent l'usage abusif ou non d'alcool.

Les recherches quantitatives sur des catégories d'emploi précises abondent également dans le sens de l'influence de l'emploi sur la consommation d'alcool, et ce, indépendamment du sexe du salarié. L'étude de Shore (1985) indique que les motifs donnés par la majorité des buveuses excessives sont le stress professionnel, la discrimination et des pressions diverses. L'étude de Markowitz (1984), quant à elle, illustre que le sentiment d'impuissance perçu est relié aux résultats du questionnaire CAGE.

L'auteur explique que :

> *"perceived powerlessness may be more potent if it occurs in a highly valued aspect of individual's life. Those who place a highly valued aspect on individual's life those who place a higher value on their jobs per se or who view their job as reflections of themselves may be prone to job related-stress with the resultant increased tendency to develop a drinking problem"*
>
> *(Markowitz, 1984, p. 227)*

Ce commentaire devient intéressant quand on sait combien la vie professionnelle constitue un aspect important de la vie des femmes contemporaines.

Bref, pour l'ensemble des travaux concernant l'emploi comme facteur de risque, on retient que des caractéristiques organisationnelles et la façon dont les femmes vivent leur expérience professionnelle pourraient contribuer à l'apparition ou à la perpétuation d'un problème d'alcool.

Par ailleurs, une recherche effectuée récemment auprès de 574 salariés (51 p. 100 étaient des femmes) laisse entendre que la relation stress-alcool pourrait être plus complexe. Alors qu'ils testaient un modèle de gestion du stress professionnel par la consommation d'alcool, Cooper, Russell et Frone (1990) ont découvert que la relation entre la détresse et la consommation d'alcool était généralement significative et positive chez les individus qui maintenaient de fortes attentes positives à l'égard de l'alcool. En conséquence, les auteurs suggèrent que l'on tienne compte des différences individuelles et des caractéristiques structurelles de l'environnement de travail (normes, culture, réseau encourageant

à boire ouvertement ou en cachette) dans les recherches à venir.

Quelques articles récents portant sur les conditions de travail et sur le bien-être physique et psychique des salariés aident aussi à faire le point sur les connaissances relatives du paradigme emploi-stress-alcool (Lowe & Northcott, 1988; Klitzman, House, Barbera & Mero, 1990; Cooper & Melhuish, 1984; Crespy, 1984). Ces articles font ressortir deux points importants : 1) les conditions de travail ont un effet crucial sur la détresse du personnel féminin et masculin, et 2) le concept du stress différentiel serait expliqué par des variantes étiologiques différentes pour les deux sexes et relié dans les deux cas au monde du travail.

Ce n'est que tout récemment que la recherche s'est consacrée à l'identification des sources de stress socioprofessionnel chez les femmes par rapport à l'usage abusif de drogues. À cet égard, les recherches montrent que les relations interpersonnelles sont un facteur déterminant. Rappelons tout d'abord que plusieurs études ont mentionné qu'une relation chaotique avec son supérieur immédiat serait une cause principale de stress professionnel chez les femmes, sans lien direct avec l'usage de drogues (Haynes & Feinleib, 1980; Kandel, Davies & Raveis, 1985; Pugliesi, 1988). L'enquête de Balshem (1988), menée auprès de 974 adjointes administratives, donne un aperçu des éléments créateurs de stress découlant de la relation avec son supérieur. Les commentaires négatifs des femmes qui participaient à cette étude portent sur le manque de respect pour le métier d'adjointe administrative, la non-reconnaissance de leurs aptitudes, laquelle se traduit par un refus de donner des responsabilités, la non-appréciation de l'importance de leur travail et des difficultés inhérentes à celui-ci, une supervision inconstante ou multiple (par plusieurs patrons) et le harcèlement sexuel et émotionnel. Dans le cadre de la recherche qualitative de Morissette (1990), la relation avec le supérieur est la principale dimension que les femmes qui font un usage à risque d'alcool associent à un changement dans leur consommation. Celles-ci dénoncent le peu de reconnaissance de leur supérieur pour des accomplissements exceptionnels, le manque d'appréciation du rendement, l'absence de soutien émotionnel et technique, leur incompétence et leur indifférence. Dans d'autres cadres, la nécessité de contacts répétés avec un supérieur dans des transactions dites «gatekeeping» est aussi associée à l'usage de drogues (Wallston, Hoover-Dempsey & Brissié 1989). Ces quelques données montrent que le manque d'appui du supérieur est un élément crucial dans la problématique de l'usage de drogues chez les femmes. La documentation signale aussi que le manque d'appui des collègues semble être un élément important (Morissette, 1990; Pugliesi, 1988). L'appui social serait là où les besoins sur les plans social et émotionnel sont satisfaits grâce à l'interaction avec autrui (Thoits, 1982). L'appui social serait de type socio-émotionnel (compagnon, conseiller), de type instrumental (aide pratique), ou cognitif (aider à comprendre une question).

Par ailleurs, la recherche tend à démontrer que le même lien existe entre le manque d'appui sur le plan privé et l'usage abusif de drogues. Lors d'une revue de la documentation portant sur la femme et l'héroïne, Tucker (1982) constate qu'en l'absence d'appui, les femmes, plus que les hommes, ont recours à des stratégies non sociales et dysfonctionnelles pour composer avec leur colère et leur dépression. Dans une étude qualitative sur la signification de la consommation quotidienne de benzodiazépines (Valium et

Librium) des femmes au foyer et des salariées, Gabe et Thorogood (1986) concluent que la disponibilité des ressources, entre autres le soutien social et la satisfaction, joue un rôle crucial dans l'usage quotidien et à long terme de benzodiazépines. Le soutien social de personnes importantes (conjoint, parent, ami, supérieur) est vue par les femmes de différentes manières selon les auteurs : premièrement comme une variable individuelle différentielle qui contribue à la qualité de l'environnement social (Sarason, Sarason & Shearin, 1986), deuxièmement, comme un facteur ayant un effet modérateur sur le stress professionnel quotidien (Morissette, 1990) et troisièmement, comme une dimension ayant un effet compensatoire pour un climat organisationnel général adverse (Repetti, 1987).

Le cumul des rôles

La documentation publiée au début des années 1980 fait ressortir que la surcharge et les conflits de rôles sont des conséquences du nouveau rôle joué par les femmes. En outre, le stress qui en découle est un élément critique de la vulnérabilité des femmes en matière d'usage abusif d'alcool. Des enquêtes épidémiologiques sur le rôle de mère-femme au travail illustrent que certaines combinaisons de rôles multiples (mère-conjointe-salariée) rendent les femmes plus sujettes à développer des problèmes liés à l'alcool (Johnson, 1982). Cette hypothèse du conflit des rôles liés à la consommation d'alcool chez les femmes a été reprise dans plusieurs articles mais n'a pas souvent fait l'objet d'une démonstration scientifique (Finley, 1982; Vicary, Mansfield, Cohn, Koch & Young, 1985).

L'intérêt actuel de la recherche sur le rôle de mère-salariée porte sur le cumul des rôles. Dans l'ensemble, les études indiquent que le choix d'être mère, conjointe et salariée ne présente pas de risque particulier pour la santé et l'usage abusif d'alcool, sauf si ces rôles sont joués dans le cadre d'une structure familiale déficiente (Verbrugge, 1982a, 1983, 1986; Thoits, 1983; Wilsnack & Cheloha, 1987).

Le manque de temps et d'énergie

On a aussi associé l'usage de tranquillisants au stress des femmes qui occupent des postes de cadres et de professionnelles. Dans l'étude de Brown-Rowat et Amsel (1990), on apprend que plus les femmes travaillent pendant des heures prolongées, plus elles vivent un stress élevé et plus elles consomment des tranquillisants. Dans cette étude, les femmes les plus stressées sont aussi celles qui ont de mauvaises habitudes alimentaires, qui ne prennent pas le temps de se détendre ou de prendre soin d'elles-mêmes. On peut discerner chez ces femmes un manque de temps et d'énergie comme facteur ayant une influence sur l'usage de drogues. Chez les salariées de l'étude de Morissette (1990), les cadres, les membres d'une profession libérale et les mères au travail rapportaient également prendre de l'alcool dans le but précis de se détendre rapidement après une journée de travail. Ces femmes déclaraient également ne pas avoir le temps de se détendre autrement. On retrouve ici l'idée que la consommation de drogues peut être une solution «express» ou une solution facile (quand on n'a plus l'énergie) pour certaines salariées. Selon Herold et Conlon (1981), on pourrait choisir de consommer de l'alcool parce que cela requiert moins d'énergie que d'autres stratégies (p. ex., faire une promenade).

Des événements
La consommation de tranquillisants serait trois fois plus élevée pendant la ménopause (Guyon, 1990). Par ailleurs, le rapport Santé Québec (1988) mentionne que les femmes qui présentent un indice élevé d'événements créateurs de stress sont nettement plus à risque quant aux problèmes liés à l'alcool et que cette relation est beaucoup plus puissante chez les femmes que chez les hommes (5 p. 100 contre 8 p. 100). Les femmes auraient également plus tendance à vivre un plus grand nombre d'événements créateurs de stress. Bien que ces résultats ne soient pas classés par catégorie d'emploi, ils ont le mérite de jeter une lumière nouvelle sur la compréhension de la consommation d'alcool et des autres drogues chez les femmes.

Les conséquences de l'usage de drogues

Les effets sur la santé
Il n'y a aucun doute qu'une consommation abusive de drogues multiples a des répercussions sur la santé des femmes. En effet, des études révèlent que les femmes sont plus vulnérables que les hommes aux problèmes de santé liés à la consommation d'alcool (Saunders & Williams, 1983). On a depuis longtemps la certitude que le tabagisme nuit sérieusement à la santé et que, chez les femmes, la manifestation la plus évidente de cet état de chose est le cancer du poumon (Mahler, 1988). Des études indiquent que les conséquences associées à l'usage chronique de cocaïne sont la dépression grave, l'insomnie, la fatigue, l'irritabilité, les troubles de la mémoire et la perte totale du désir sexuel (Washton, 1986). L'usage abusif de drogues fait augmenter le nombre de tentatives de suicide chez les femmes (Ogur, 1986).

En matière de santé, l'ENAAD révèle que parmi les femmes qui déclarent avoir diminué leur consommation d'alcool ou d'y avoir mis un terme, et ce, quelle que soit la catégorie d'emploi, elles sont plus nombreuses à invoquer des raisons de santé que toute autre raison mentionnée dans l'enquête. L'ENAAD témoigne donc d'une préoccupation des Canadiennes pour leur santé et pour des modes de vie plus sains.

Les effets sur le travail
Plusieurs auteurs rapportent que les effets des psychotropes et de la consommation d'alcool peuvent affecter le rendement professionnel (Masi, 1984; Roman, 1988a, 1988b). Il est toutefois très difficile d'évaluer les répercussions de la consommation d'alcool sur le travail des femmes puisque cette question est rarement étudiée (Penniman & Agnew, 1989). Toutefois, des chômeuses en traitement mentionnent avoir perdu leur emploi pour des motifs liés à leur consommation d'alcool (Dritschel & Pettinati, 1989). Selon Robbins (1989), les femmes pourraient limiter leur usage d'alcool ou de drogues à certaines occasions ou à certains moments de manière à éviter les conflits dans leur rôle. Les résultats de l'étude de Morissette (1990) suggèrent également que les consommatrices d'alcool à risque boivent pour ne pas affecter leur rendement professionnel.

Les effets sur la conduite automobile
L'usage abusif de drogues et d'alcool serait aussi associé à des arrestations pour conduite en état d'ébriété. Ce serait toutefois plus souvent le cas chez les hommes que chez les femmes (Gomberg, 1979; Shore, McCoy, Martin & Kuntz, 1988).

Dans l'étude de Shore, et al. (1988), plus de salariées que de femmes au foyer et de femmes au chômage se font arrêter. La majorité des salariées occupent un emploi dans le secteur des services : serveuses de restaurant, femmes de ménage, employées dans la restauration rapide.

Conclusion

Selon la documentation scientifique et l'ENAAD, on observe que les femmes qui font usage de drogues occupent toutes les catégories d'emploi. Il semble aussi que les salariées soient plus nombreuses que les femmes au foyer à faire usage d'alcool et de drogues illégales et à présenter des problèmes liés à leur consommation. Dans le cas de la consommation de médicaments, le phénomène prévaut surtout chez les femmes au foyer.

Certaines catégories de salariées seraient plus à risque à l'égard de l'alcool, suivant certaines variables. Selon l'âge, il semble que les plus jeunes femmes sont plus à risque; selon l'état civil, ce serait les célibataires, séparées ou divorcées; selon les catégories professionnelles, on parle des cadres, professionnelles et cols blancs; selon le revenu et la scolarité, les femmes dont le revenu est élevé et les plus scolarisées; enfin, selon la situation de vie, les femmes vivant seules. Les femmes qui répondent à ces critères sont considérées à plus haut risque car elles consomment plus d'alcool que les autres femmes ou le font plus souvent.

La documentation scientifique et l'ENAAD permettent aussi d'établir un lien entre le stress et la consommation de drogues chez les femmes au foyer et les salariées. À ce sujet, plusieurs études donnent des réponses préliminaires sur les facteurs structurels ou organisationnels à l'origine du stress professionnel des salariées. Chez les femmes au foyer, le stress prendrait sa source dans l'insatisfaction par rapport à leur rôle et serait à l'origine de leur sentiment de frustration, d'ennui ou d'incompétence. Le manque d'appui dans leur vie professionnelle ou privée est un élément important.

Par ailleurs, il ressort de nos sources de données que, plus souvent qu'autrement, les femmes consomment le soir et les fins de semaine. Les lieux où elles boivent varient en fonction de l'âge et la catégorie d'emploi. En général, les femmes au foyer et les salariées d'âge moyen et les femmes âgées (plus de 50 ans) boivent dans des lieux privés et semi-privés tandis que les jeunes femmes et les femmes au chômage consomment davantage dans les endroits publics (bars et restaurants). Quelques études indiquent aussi que les salariées ne boivent pas régulièrement avec leurs collègues de travail. La tendance à consommer de l'alcool chez les femmes irait de pair avec celle du partenaire. Des indications liées à la consommation d'accompagnement seraient à considérer (p. ex., apprendre à consommer avec lui et à aimer certains types d'alcool).

Les femmes au foyer et les salariées ont tendance à utiliser concurremment divers types de drogues légales ou illégales. Enfin, bien peu de femmes boivent seules et tous les jours.

Les articles consultés suggèrent également que, quel que soit le produit, les femmes au foyer et les salariées auraient tendance à consommer pour les mêmes raisons, bien qu'il ne s'agisse pas toujours de la même drogue. Plusieurs facteurs joueraient un rôle important dans le choix de la drogue (influence des parents, influence du partenaire et des pairs, publicité, croyances et attentes, manque de temps et d'énergie).

Notes

1. Dans la présentation des résultats de l'enquête, l' expression femmes comprend les trois groupes réunis, soit salariées, chômeuses et femmes au foyer. Dans les autres cas, les groupes comparés seront clairement mentionnés.

2. Celle de l'accroissement de la consommation des femmes et de la diminution de la consommation des hommes qui devait égaliser ou presque le niveau de consommation des hommes et des femmes.

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CHAPTER 6

Women Aged 65 and Over: Alcohol and Drug Use[1]

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Introduction

National and regional surveys carried out in Canada during the past decade (Adlaf, Smart & Canale, 1991; Adlaf, Smart & Jansen, 1989; Health and Welfare Canada, 1988; Health and Welfare Canada & Statistics Canada, 1981; Lexchin, 1989; Miller, 1988; Statistics Canada, 1987) have found that alcohol and tobacco use among older women is lower than other age–gender groups while use of prescription drugs tends to be highest among older people generally, and women in particular. These trends have also been evident in the United States (Hilton, 1988a; Robbins & Clayton, 1989; Stephens, Haney & Underwood, 1981; Whittington, Petersen, Dale & Dressel, 1981).

Results from three previous Canadian national surveys regarding drinking, smoking, use of tranquillizers and sleeping pills, and use of cannabis are shown in Table 6.1. As is evident from these results, the prevalence of drinking among older women is lower than among men and younger people generally, with approximately 50 per cent of older women being current drinkers compared with over three-quarters of all adult women. Older women also have the lowest rate of smoking of any age–gender subgroup. Because of these trends, substance use by older women has been largely ignored. The focus of previous research has been primarily alcohol and illicit drugs; therefore, extended analyses have focused on those subpopulations containing heavier users of these substances, namely, younger people and males. As a result, there is little knowledge about substance use and related problems among older women. In addition, prescrip-

tion drugs, used most heavily by women, especially older women, have been all but ignored in population drug use studies. In contrast to drinking and smoking, use of prescribed and over-the-counter medications increases with age in the adult population, with older women being most likely of all adult age–gender groups to report using one or more classes of drugs, including higher use of psychoactive prescription drugs (see Table 6.1).

Table 6.1

Percent of Older Women Who Used Alcohol, Tobacco, Psychoactive Prescription Drugs and Marijuana Compared with Other Population Subgroups (National Survey Reports 1978–85[a])

Note: CHS = Canada Health Survey 1978–79
CHPS = Canada Health Promotion Survey 1985
GSS = General Social Survey Health and Social Support 1985
[a] Time periods over which use was assessed varied among surveys.

	Women Aged 65+ (%)	All Women (%)	Men Aged 65+ (%)	All Men (%)
Alcohol				
CHS	51	76	68	85
CHPS	52	77	72	86
GSS	51	77	71	85
Tobacco				
CHS	15	37	32	41
CHPS	18	32	20	36
GSS	17	37	26	34
Sleeping pills				
CHPS	23	10	18	6
Tranquillizers				
CHPS	14	8	8	5
Sleeping pills or tranquillizers				
CHS	20	7	10	3
Marijuana (cannabis)	–	4	–	7

Results of several surveys suggest that overall trends in current use of alcohol and prescribed psychoactive drugs have been stable or decreasing over the last decade, though for alcohol the proportion of former drinkers has increased while the percentage of lifetime abstainers has decreased (Health and Welfare Canada & Statistics Canada, 1981; Health and Welfare Canada, 1988; Statistics Canada, 1987). Data from the biannual surveys of Ontario adults (1977–91) also confirm that the prevalence of alcohol and sleeping pill use is stable among older women (50+ years), but that tranquillizer use appears to be declining in this age group (Adlaf, Smart & Canale, 1991). In contrast, there is some evidence of increased rates of smoking among older women. Using data from the Smoking Supplement to the Labour Force Survey, Miller (1988) found a slight increase in smoking prevalence among older women (65+ years) in the 20-year period from 1966–86. He hypothesized that this trend will continue as women who were in their teens in the Second World War enter the 65+ age group. With an aging population, including the large proportion of women among older people, it is timely to examine substance use patterns by older women in more depth.

Factors Related to Substance Use in General Population Surveys

A number of demographic and lifestyle factors have been found to be associated with substance use. Drinking and smoking are positively related to each other, and both decline with age; however, the factors that are related to these behaviors are somewhat different (Health and Welfare Canada & Statistics Canada, 1981; Health and Welfare Canada, 1988; Statistics Canada, 1987). Current and former smokers and former drinkers are more likely to report health problems, while current drinkers are more likely to report good to excellent health, fewer health problems, and positive emotional state than former drinkers (Health and Welfare Canada & Statistics Canada, 1981; Statistics Canada, 1987). Current drinkers are also more likely to be better educated, to be employed and to have a higher income than non-drinkers. Smokers, on the other hand, are more likely to report lower education levels and are more likely to be unemployed than non-smokers (Health and Welfare Canada 1981, 1988). Low rates of current drinking have been found among those who are retired or who are homemakers and those who are widowed (Health and Welfare Canada, 1988).

While use of alcohol and tobacco decreases with age, prescription drug use tends to increase (Health and Welfare Canada, 1988). In addition, higher rates of use have been found among women; Francophones; those who are widowed, separated or divorced; those with lower education levels; and those with lower income levels (sleeping pills only) (Adlaf, Smart & Canale, 1991; Health and Welfare Canada, 1988). Although analyses of general population trends have identified some stable predictors of substance use, reports have not indicated whether factors associated with use of substances in the general population also predict use patterns among older women.

Problem Use Patterns

Not only are older women more likely to be abstainers; they also tend to have low rates of heavy or problem drinking. In a study of older adults (60+ years) living in senior citizens' apartments in Toronto, very few older women met the criteria for heavy drinking; 1.7 per cent reported drinking more than one ounce of absolute alcohol

daily and 1.2 per cent reported drinking five or more drinks at a single sitting (Adlaf, Smart & Jansen, 1989). Two U.S. surveys of a group of women (where moderate to heavy drinkers were oversampled) in 1981 and 1986 (Wilsnack, Wilsnack & Klassen, 1984, 1987; Wilsnack, 1989) also showed low rates of alcohol problems among older woman, with about three per cent of all older women respondents reporting that they consumed more than one ounce of ethanol daily, two per cent reporting six or more drinks per day four or more times in the preceding year, and one per cent reporting symptoms of alcohol dependence. Finally, analyses of data from a 1985 National Household Survey on Drug Abuse (U.S.) indicated that four per cent of women aged 65 and over reported one or more of 18 problem drinking symptoms, and one per cent reported one or more of five personal consequences of alcohol or drug use (Robbins, 1991).

With regard to prescription drug use, several surveys have found multiple use of psychotherapeutics to be more likely to occur among older women than other age–gender groups (Health and Welfare Canada, 1988; Adlaf, Smart & Canale, 1991).

In summary, the general pattern of substance use by older women has included mostly light non-problematic alcohol use, increasing use of cigarettes, and a higher rate of prescription drug use than other subpopulations. Data from the recent National Alcohol and Other Drugs Survey (NADS) were analyzed to explore further patterns of use of alcohol and other drugs by older women. In particular, this paper examines extent of use, consequences of use, apparent trends in use, and factors associated with use.

There are a number of reasons for focusing on older women. First, because of their lower rate of use of alcohol and illicit drugs, little attention has been paid to this segment of the population. As the proportion of older women in the population increases, planning and policy should be undertaken with specific knowledge of their use patterns, not just by generalizing from analyses of patterns of use among younger people. Second, there has been speculation in the addictions field regarding a major cohort effect (especially among women) because of general liberalization of attitudes toward alcohol and some illicit drugs (Mishara & McKim, 1993). Longitudinal data of drinking by men suggest that recent cohorts have not been reducing their drinking as they age (Glynn, Bouchard, LoCastro & Hermos, 1984). Corresponding data have not been available for women. The lack of longitudinal research on women highlights the need to understand alcohol and drug use among the current population of older women in order to identify potential age/cohort differences.

Methodology

The National Alcohol and Other Drugs Survey (NADS) was conducted by Statistics Canada in March 1989. It is the first national survey to focus specifically on alcohol and drug use and associated problems. Households were selected using random digit-dialling methods. The response rate was 79 per cent of those contacted, with the final sample consisting of 11,634 persons aged 15 years and older. The survey did not include institutionalized persons or those not accessible by telephone. (For a more detailed account of the NADS methodology, see Chapter 15.)

There were 1,118 female respondents who were aged 65 years and over. This age group of women was slightly overrepresented, with 9.6 per cent of survey respondents versus 7.7 per cent of women

of this age group in the general population (1986 Canadian census data). Because provinces with lower populations were oversampled in the survey, the use of compensation weights has been recommended when analyses are conducted across all provinces. Using these weights resulted in a sample size of 759 older women (aged 65+). Most analyses used this sample, although some analyses included all respondents (men and women) who were aged 20 and over. Persons aged 15 to 19 were excluded from all analyses. The following sections describe the results of descriptive, bivariate and factor analyses that were undertaken to profile substance use patterns and correlates of substance use among older women.

Respondent Profile

To assess the extent to which older female respondents to the NADS survey reflected the population of Canadian women aged 65+, characteristics of respondents were compared with characteristics of women aged 65+ in the 1986 census. In terms of age grouping and marital status, women aged 65+ who responded to the survey reflected the 1986 census, with almost two-thirds between the ages of 65 and 74 and most women either widowed (48 per cent) or married (42 per cent). In other respects, women aged 65+ included in the NADS survey were higher functioning than the population of women in this age group (as reflected in the 1986 census data). First, the survey did not include the 10 per cent or so of women aged 65+ who do not reside in private households (1986 census). Second, respondents to the survey were better educated than is typical for women in this age group. Twenty-nine per cent of survey respondents reported having elementary school education or less compared with 45 per cent of older women in the 1986 census. The NADS survey also undersampled those whose home language was neither French nor English. Of NADS respondents, 73 per cent reported that their home language was English, 25 per cent French and 2 per cent another language, while the 1986 census indicated that 13 per cent of women aged 65+ reported a home language of neither French nor English.

Other characteristics of the NADS sample of older women included: three-quarters of the respondents felt that their health was good to excellent; two-thirds reported that life was either not very stressful or not stressful at all; and over 90 per cent of respondents were either retired or keeping house. In sum, the women aged 65+ who responded to the NADS survey are generally representative of well-functioning women in this age group who speak English or French.

Results and Discussion

Alcohol Use

Compared with other age–gender groupings, women aged 65+ were most likely to be both lifelong abstainers and former drinkers[2] and least likely to be current drinkers (see Table 6.2). This appears to reflect both an age and a gender effect. Older women and men were more likely to be lifelong abstainers than their same-sex younger counterparts (apparently, a cohort effect) and more likely to be former drinkers (which could be an age and/or cohort effect). There was also a gender effect, in that women were more likely than men in the same age group to be lifelong abstainers and to be former drinkers. The higher rate of lifelong abstainers among older women compared with younger women indicates that increased rates of drinking among future cohorts of older women are likely.

Table 6.2
Use of Substances by Older Women Compared with Younger Women, Older Men and Younger Men

[a] Comparisons were made to younger *adults*; therefore, those who were 15 to 19 were excluded from the analyses.
[b] Percentages based on all respondents (with percent of current drinkers provided in parentheses).

	Women Aged 65+ (n=759)	Women Aged 20-64[a] (n=3,862) (%)	Men Aged 65+ (n=567) (%)	Men Aged 20-64[a] (n=3,815) (%)
Lifelong abstainers	21	7	7	2
Former drinkers (i.e., persons who drank at some time but not in the past 12 months)	34	16	28	10
Current drinkers (i.e., persons who drank during the previous 12 months)	46	77	66	87
Drinks 4 or more times/week[b]	5 (10)	4 (6)	21 (32)	13 (14)
Drinks 5 or more drinks on one occasion at least once/month[b]	1 (2)	5 (7)	5 (8)	21 (24)
Never smoker	63	43	24	35
Former smoker	21	23	54	29
Current smoker	17	34	22	37
Drugs (illicit): ever used marijuana	1	20	1	34
Psychoactive prescription drugs used during past 30 days:				
•tranquillizers	7	4	4	2
•sleeping pills	12	4	10	2
•antidepressants	3	3	3	1
•narcotic analgesics	5	6	3	4
used at least one of: •tranquillizers, sleeping pills, •antidepressants, or narcotic •analgesics	20	13	14	8

Age-gender effects are also apparent regarding drinking patterns among current drinkers. In general, older women and men reported drinking more frequently than their same-sex younger counterparts but drank lower amounts per drinking occasion (e.g., were less likely to drink five or more drinks on an occasion). In addition, women drank less frequently and were less likely to consume five or more drinks on an occasion than males of the same age group. High-volume drinking appears to be an activity of the young, while high-frequency, low-volume drinking characterizes older people. There is no reason to assume that this pattern will be different as women in younger age groups grow older. However, if future cohorts of older women show lower rates of abstaining (as projected), this may result in an increase in current drinkers and a corresponding increase in high-frequency and high-volume consumers overall, since the proportion of heavy drinkers in a population tends to be positively correlated with average consumption levels (Skog, 1993).

Reasons for Drinking

Table 6.3 shows reasons for drinking among age–gender groups. These percentages are based only on current drinkers. As is evident in this table, social reasons for drinking (e.g., to be sociable, to add to the enjoyment of meals) were cited at about the same rate across age–gender groupings. Instrumental reasons for drinking (e.g., to feel good, to forget worries), however, showed the same age–gender trends as drinking consumption patterns. These differences are important, as instrumental reasons for drinking have been shown to be associated with heavy or problem drinking (Lex, Mello, Mendelson & Babor, 1989). Older women indicated lower rates of all instrumental reasons for drinking than younger women. In addition, women in general reported lower rates of all instrumental reasons than men in the same age group. If the higher rate of instrumental reasons for drinking by younger women cohorts stays the same as they age, however, this combined with lower abstention rates could put future populations of older women at increased risk for alcohol-related problems.

Negative Consequences of Alcohol Use

The data were analyzed to estimate lifetime prevalence of alcohol-related problems, based on responses to two questions asked in different parts of the survey. In one section, current drinkers were asked whether they had experienced any negative consequences of drinking during the past 12 months. In a different part of the survey, both current and former drinkers were asked to provide reasons why they had ever quit or reduced drinking. Data from these two questions were combined to estimate lifetime prevalence of problems for *both* current and former drinkers. An area was considered "problematic" if a harmful effect had been reported by current drinkers *and/or* it was cited as a reason for quitting or reducing drinking. The results are shown in Table 6.4, where percentages are provided based on the total sample of respondents (not just among current or former drinkers). As is evident from this table, problems were very infrequent among older women compared with other groups.

Table 6.3

Percent of Those Endorsing Each Reason for Drinking Among Age–Gender Subgroups of Current Drinkers

	Women Aged 65+ (n=334-5)[a] (%)	Women Aged 20-64[a] (n=2952-61)[a] (%)	Men Aged 65+ (n=367-8)[a] (%)	Men Aged 20-64[a] (n=3325-7)[a] (%)
To be sociable	75	74	74	71
To add to the enjoyment of meals	50	41	49	46
To feel good	17	23	32	34
To help relax	25	34	42	46
To forget worries	7	7	10	12
To feel less inhibited or shy	4	11	6	14

[a] The numbers vary slightly because of missing responses.

The different rates of ever experiencing alcohol-related problems for women aged 65+ compared with women aged 20 to 64 may indicate growing levels of problems among women. Theoretically, these questions are measuring *lifetime* prevalence of problems. That is, if a person reports at age 30 that she has ever experienced harmful effects of alcohol on friendship or social life, she should still report that same harmful effect at age 80. Therefore, the lower rate of lifetime prevalence of alcohol-related problems among older women would be interpreted as a cohort effect, with higher rates of problems anticipated for future cohorts of older women.

On the other hand, the lower rates of lifetime prevalence of alcohol-related problems among older women could reflect response bias, sampling bias or other factors. First, those who have major alcohol problems are more likely to have died or been institutionalized by age 65 (and therefore be excluded from the survey). If they are still experiencing alcohol problems, they may have been more likely to refuse to participate in the survey. Finally, by age 65, the respondent may have forgotten about minor harmful effects experienced in early adulthood or may no longer define these effects as "harmful." Thus, although it seems likely that there is some cohort effect (and rates of consumption and problems will be higher for future cohorts of women aged 65+), more needs to be known about how older and younger people interpret questions regarding lifetime prevalence of harmful effects. More also needs to be known about potential sampling bias of telephone surveys with older respondents. Are those elderly who are experiencing the consequences of chronic alcohol abuse more likely to decline to participate (because of consequences directly related to alcohol abuse, such as cognitive impairment) as well as being missed entirely in the sample because of residing in an institution? If future national surveys are to be useful for estimating the alcohol use and related problems of older people, these response issues need to be addressed.

Table 6.4

Percent of All Respondents Who Reported That Alcohol Had Ever Had a Harmful Effect[a] on a Life Area and/or Reported Having Quit or Reduced Drinking Because Alcohol was Affecting That Area[b]

	Women Aged 65+ (n=759) (%)	Women Aged 20-64[a] (n=3862) (%)	Men Aged 65+ (n=567) (%)	Men Aged 20-64[a] (n=3815) (%)
Friendships or social life	1	7	7	15
Physical health	5	12	16	23
Outlook on life (happiness)	1	7	6	12
Home life or marriage/ family or home life[c]	1	5	6	12
Work, studies or employment opportunities	1	5	5	13
Financial position	1	5	6	13
At least one area cited as problematic	7	18	23	36

[a] Asked only of those who had consumed alcohol during the previous 12 months.
[b] Asked of current and former drinkers.
[c] Asked slightly differently in the two questions.

Becoming a "Former Drinker"

With regard to reasons for quitting or reducing drinking, some interesting findings emerged among the respondents who said that they had not drunk during the previous 12 months but were not lifelong abstainers. These respondents are referred to as "former drinkers" in Health and Welfare reports such as *The National Alcohol and Other Drugs Survey Highlights Report* (1990). Of the 256 women aged 65+ who were classified as "former drinkers," however, only 22 (eight per cent) reported that they had ever stopped and/or reduced drinking for a time. Presumably, the remaining 92 per cent of former drinkers had either quit without trying or were actually infrequent current drinkers who had not happened to consume alcohol during the previous 12 months. There are both age and gender differences among the rate of former drinkers who reported stopping or reducing drinking at some time. While only eight per cent of older female former drinkers and 16 per cent of younger female drinkers reported a conscious attempt to stop or reduce drinking, *55 per cent* of younger male former drinkers (36 per cent of older male drinkers) reported stopping or reducing drinking. In sum, those classified as "former drinkers" among women appear to be quite different from "former drinkers" among men. For men (especially younger men), the term "former drinker" seems accurately to reflect many in this group. For women, particularly older women, the group classified as "former drinkers" probably includes substantial numbers who are either very infrequent current drinkers or persons whose drinking pattern is almost lifelong abstention. Unfortunately, the survey responses contained very little information about this group of sometime drinkers. In trying to project future drinking patterns among persons aged 65+, we need to have a better understanding of the large proportion of elderly women (and men) who are currently classified as "former drinkers."

Smoking and Illicit Drug Use

Smoking

Smoking patterns among age–gender groupings resembled drinking patterns (see Table 6.2). Women aged 65+ were most likely to be never smokers and least likely to be current smokers. Women generally were more likely than men to have never smoked. However, these differences between men and women are much larger for respondents aged 65+. In addition, age differences are greater than gender differences for rates of current smoking. As has been observed in other studies of smoking patterns (Health and Welfare Canada, 1988), a definite cohort effect is evident among women, with higher rates of smoking among younger cohorts and little difference in smoking practices between younger males and females. The rise in smoking rates among women will have some obvious health impacts for future cohorts of older women.

Illicit Drug Use

The only illicit drug that will be discussed in any detail here is marijuana, since it is the most frequently used illicit drug. Other illicit drugs were excluded because rates of use tend to be too small to allow meaningful comparisons across subgroups, and experience with illicit drugs other than marijuana tends to be restricted almost entirely to those 44 years old and under (Health and Welfare Canada, 1990). Marijuana, although more frequently used

than other illicit drugs, is also rarely used by older people. As shown in Table 6.2, only one per cent of women or men over age 65 reported ever using marijuana, while 20 per cent of younger women and 34 per cent of younger men reported use. Analyses by age group indicated a trend for increased use by each successive cohort for both women and men. Among women, the following proportions reported ever using marijuana: aged 20 to 24, 37 per cent; aged 25 to 34, 34 per cent; aged 35 to 44, 18 per cent; aged 45 to 54, four per cent; aged 55 to 64, two per cent; aged 65+, one per cent. For men, the trend was similar. In addition, except for those in the younger age groups, those who had used marijuana in the previous 12 months constituted only a small proportion (10 to 20 per cent) of those who had ever used marijuana. Although there is a clear pattern for use of illicit drugs to decrease with age, it is also clear that older women of the future will be much more likely than the present cohort of older women to have had experience with marijuana and possibly other illicit drugs. While use of illicit drugs appears to drop sharply with age, this prior exposure to illicit drugs could result in a more liberal attitude toward substances generally and a corresponding increase in use of licit drugs, such as alcohol, among older women.

Psychoactive Prescription Drug Use

As with alcohol use and smoking, both age and gender effects were apparent for use of psychoactive prescription drugs. Trends in prescription drugs, however, tended to be the opposite of trends for alcohol use and smoking. Older women were most likely of all age–gender groups to use psychoactive prescription drugs (see Table 6.2). The four most commonly used types of psychoactive prescription drugs are shown in Table 6.2; these include tranquillizers, sleeping pills, antidepressants and narcotic analgesics. Both tranquillizers and sleeping pills show higher rates of use by older persons than by younger persons of the same sex. The largest age effect is for use of sleeping pills. In addition, for nearly all types of drug use, women had higher rates of use than men in the same age group. Differences in rates for some drug types tended to be small, but the pattern was consistent. As shown in Table 6.2, 20 per cent of older women reported using at least one psychoactive prescription drug during the previous 30 days.

The National Alcohol and Other Drugs Survey included only a few questions on prescription drug use. Therefore, there is not a great deal of information on which to base interpretation of prescription drug use trends. The higher use of sleeping pills by older people is consistent with other research suggesting that older people have more health problems and tend to use more prescription drugs generally than younger people (Health and Welfare Canada, 1988).

Reasons for higher use of psychoactive prescription drugs by women generally and older women specifically are not apparent from data in the present survey, although this pattern has been found in previous surveys (Health and Welfare Canada, 1988). The following explanations are possible and need to be explored in future research on prescription drug use. First, high use of psychoactive prescription drugs may be related to higher morbidity rates among women. Some studies have found that women have higher morbidity rates while men have higher mortality rates (Doyal, 1990; Waldron, 1986). Second, it may be more socially acceptable for

women to be prescribed and to use psychoactive prescription drugs than it is for men. This attitude may reflect both sexism in prescribing practices by physicians (see Cormack, Owens & Dewey, 1989; Glantz & Backenheimer, 1988) as well as possible stereotypic sex-role behavior among users. Finally, to the extent that use of psychoactive prescription drugs reflects self-medication, the use patterns may indicate gender differences in attitudes toward use. For example, women, particularly older women, may believe that alcohol use is wrong but use of prescribed drugs is acceptable. On the other hand, drinking alcohol may be acceptable for men, but taking Valium would be embarrassing. With these attitudes, a woman might take a drug to relax while a man would take a drink. These hypotheses are, of course, speculation. That they are only speculations illustrates the lack of existing knowledge regarding differential use of prescription drugs by women compared with men.

As the population ages, more needs to be known about use of psychoactive prescription drugs, particularly with regard to older women, who constitute the highest proportion of users. We need to know why these drugs are prescribed and how they are used. We also need to know the specific pharmacological types of drugs used (e.g., benzodiazepines), not just the function of the drug (e.g., sleeping pills). For example, the survey asked about tranquillizers and sleeping pills as two different drug types.[3] This is a functional distinction that does not necessarily reflect a pharmacological distinction, since the current practice is for most tranquillizers and sleeping pills to be prescribed from the minor tranquillizer (usually benzodiazepine) family. Therefore, the two per cent of older women who reported taking both tranquillizers and sleeping pills may well be mixing two types of minor tranquillizer medication.

Furthermore, there is reason to believe that the present survey approach tends to underestimate the number of older people who use psychoactive drugs. In the present survey, respondents were asked about use during the past 30 days (a fairly short time frame) and by function of drug (sleeping pill, tranquillizer) rather than by drug type. In contrast, a recent study in New Brunswick (Irvine-Meek, Davidson, Olmstead, Somers & Kane, 1991) examined use of benzodiazepines (usually prescribed as sleeping pills or tranquillizers) according to drug plan data for the previous 12 months. As with the NADS data, data from the New Brunswick drug plan study were based on usage during 1989. To compare results from the NADS with results from the analyses of the New Brunswick drug plan, separate analyses of the NADS were conducted using New Brunswick data only. According to the NADS survey, 15 per cent of persons aged 65 and over in New Brunswick had used sleeping pills and/or tranquillizers during the previous 30 days. On the other hand, the drug plan data indicated that 27 per cent of those aged 65 and over had filled a prescription for benzodiazepines during the 12 months of 1989. This discrepancy suggests that survey data may underestimate use considerably. The underestimate may be due to any or all of the following: 30-day time frame, sampling bias (i.e., excluding institutionalized persons), response bias (i.e., people reluctant to report use). Whatever the source of the discrepancy, these issues need to be considered when interpreting survey data regarding substance use by older people, especially older women.

We also need to know more about interactions between alcohol and prescrip-

tion drugs. Benzodiazepines in particular may have a long half-life and may tend to accumulate (depending on dose, age and size of the person). A person who is taking both tranquillizers and sleeping pills could well experience significant effects from any alcohol use. Although current use patterns do not indicate a relationship between alcohol use and prescription drug use (as described in the next section), if future cohorts of older women include more drinkers, the potential for alcohol–drug interactions could increase.

Correlates of Alcohol Use, Smoking and Prescription Drug Use among Older Women

The following variables were examined as correlates of alcohol use, smoking and prescription drug use: marital status, language usually spoken at home, education level, household income, religiosity, health status, stress level during the previous 12 months, perceived level of support from family or friends and use of other substances. Analyses consisted of X^2 tests for nominal variables and *tau b* measures of association for ordinal variables. The relationships between these variables and substance use by older women are shown in Tables 6.5, 6.6 and 6.7.

The substances examined were: alcohol, tobacco and psychoactive prescription drugs including tranquillizers, sleeping pills, antidepressants and narcotic analgesics. For analyses of alcohol use, respondents were rated as: (1) abstinent (including lifelong abstainers as well as former drinkers), (2) lighter drinkers (never drinking more than five drinks on an occasion in the past 12 months and usually drinking less than four times per week) and (3) heavier drinkers (drinking five or more drinks on at least one occasion in the past 12 months and/or drinking on average four or more days per week). For smoking, responses were coded as: (0) never or former smoker or (1) current smoker. Categories describing prescription drug use were coded as: (0) did not use during past 30 days or (1) used in the past 30 days. Because the survey asked about prescription drug use only during the previous 30 days, the number of users of any particular drug type tended to be small. Therefore, significant relationships need to be interpreted with some caution. The following section highlights some of the trends observed for older women and compares these trends with analyses of the other three age–gender groupings.[4]

Table 6.5
Relationships of Marital Status and Language with Substance Use by Older Women

[a] X^2 of level of drinking by marital status = 15.8, df = 6, p< .05
[b] X^2 of level of drinking by language usually spoken at home = 10.6, df = 4, p< .05
[c] X^2 of using sleeping pills by marital status = 16.0, df = 3, p< .01

	Marital Status				Language		
	Single	Married	Separated /Divorced	Widowed	English	French	Other
Level of Drinking[ab]							
Abstainer	55	50	52	62	53	62	71
Lighter Drinker	27	40	40	33	37	34	30
Heavier Drinker	19	10	8	6	10	4	0
Current Smoker	21	14	27	17	17	19	2
Prescription Drug Use							
Tranquillizer user	4	4	12	9	7	8	3
Sleeping Pill User[c]	11	7	3	16	11	15	4
Antidepressant User	3	2	6	4	4	2	5
Narcotic Analgesic User	2	5	4	5	6	2	1

Table 6.6
Correlations (*tau b*) of Substance Use With Other Variables Among Older Women

* p<.05.
** p<.001.
[a] Numbers vary due to missing values for some items.
[b] Single women most likely to be heavier drinkers; widowed most likely to be abstainers and to use sleeping pills.
[c] Those whose home language is neither English nor French most likely to be abstainers.

	Level of Drinking (0=abstainer, 1=lighter-drinker, 2=heavier-drinker) (n=536 to 635)[a]	Smoking (0=non-smoker, 1=current smoker) (n=545 to 759)[a]	Psychoactive Prescription Drug Use (0=no use in past 30 days 1=used during past 30 days) (n=545 to 759)[a]			
			Tranquil-lizers	Sleeping Pills	Anti-depressants	Narcotic Analgesics
Age group [(1) 65–69, (2) 70–74, (3) 75–79, (4) 80+]	–.13*	–.07*	–.02	.06*	.02	–.05
Education level[(1) elementary, (2) some secondary, (3) completed secondary, (4) non-university postsecondary, (5) university]	.15**	.01	.01	–.10*	–.02	.01
Household income from all sources [(1) less than $5,000 to (8) $60,000+]	.19**	.01	–.08*	–.07*	–.06	.04
Religiosity [(1) not very religious, (2) moderately religious, (3) very religious]	–.17**	–.17**	.02	.08*	.01	.00
Health status [(1) poor, (2) fair, (3) good, (4) very good, (5) excellent]	.12*	–.10*	–.09*	–.21**	–.07*	–.12**
Stress level [(1) unstressful, (2) not very stressful, (3) fairly stressful, (4) very stressful]	–.04	.01	.07*	.19**	.11**	.01
Perceived level of support from family or friends [(1) not very helpful, (2) somewhat helpful, (3) helpful, (4) very helpful]	.01	–.09*	–.03	–.20**	–.04	–.03

Table 6.7
Relationships among Use of Selected Substances (Kendall's *Tau b*)

* p<.05.
** p < .001.

	Level of Drinking (0=abstainer, 1=lighter-drinker, 2=heavier-drinker) (n=745)	Smoking (0=non-smoker, 1=current smoker) (n=759)	Psychoactive Prescription Drug Use (0=no use in past 30 days 1=used during past 30 days) (n=759)			
			Tranquil-lizers	Sleeping Pills	Anti-depressants	Narcotic Analgesics
Level of drinking	–					
Smoking	.16**	–				
Tranquillizers	–.01	.08*	–			
Sleeping pills	–.01	.12**	.17**			
Antidepressants	.04	.10*	.18**	.19**	–	
Narcotic analgesics	.02	.04	.08*	.18**	.13**	–

Among older women, the following characteristics were associated with drinking: single, not widowed, English language, younger, more educated, higher income, less religious, better health, and present smoker. Except for language (which applied only to women) and marital status (not related to alcohol use by older men), these relationships tended to apply across age–gender groupings.

Smoking by older women was related to the following characteristics: younger, less religious, poor health, less perceived support from family, and use of alcohol, tranquillizers, sleeping pills and antidepressants. For younger women, the same relationships were observed (except for the relationships of smoking with use of sleeping pills and antidepressants). The relationships between these variables were different for older versus younger men, with low religiosity, poor health and tranquillizer use associated with smoking by men under 65, while low support and antidepressant use were associated with smoking by older men.

Regarding sleeping pill use by older women, the following characteristics were identified: widowed, older, lower education, lower income, more religious, poorer health, more stress, less support, current smoker and use of other psychoactive prescription drugs. Of these characteristics, only age, income, stress and use of other psychoactive drugs were consistently related to use of sleeping pills across age–gender groupings.

Among other prescribed psychoactive drugs, the most consistent relationship tended to be with poor health, higher stress and concurrent use of other prescribed drugs. These relationships tended to be consistent across age–gender groupings.

Overall Patterns Related to Substance Use

To better describe the relationships among substance use and potential predictors included as part of the survey, factor analyses (principal component solution) were performed on the data set for women aged 65 and older as well as on the data for all respondents aged 20 and over.[5] Six factors emerged from each analysis using the criterion of eigenvalue greater than one, with 52 per cent of the variance accounted for in both solutions.

Table 6.8 shows the results of the factor analysis for older women. The first three factors seemed to tap patterns related to substance use, while the last three reflected demographic patterns. The first factor identified a dimension that included lower religiosity, more drinking and more smoking. This dimension was quite robust across solutions (i.e., solutions using fewer components) and appeared as a distinct factor in the analysis for all adult respondents as well. The negative relationship between religiosity and drinking was very consistent.

The second factor was also robust across solutions, indicating a pervasive psychoactive prescription drug-taking dimension. In some solutions for the data on older women and in the analyses for all adults, health and stress also loaded on this factor, with poorer health and higher stress associated with drug taking. In a few instances, smoking emerged as part of this dimension.

The third factor in the solution in Table 6.8 showed what might be considered a "well-being" dimension with better health, less stress and higher education associated with less use of sleeping pills or analgesics. In the analysis for adults, this dimension included alcohol consumption and not drugs and was strong and consistent across solutions. The factor was less consistent for various solutions of the data on older women. Thus, while there was some evidence that among older women, being younger, healthier and better educated is positively associated with alcohol use and negatively with use of psychoactive prescribed drugs, the exact pattern of this dimension was not stable, although this dimension tended to be very stable in analyses of the overall adult population.

Table 6.8

Factor Analysis With Varimax Rotation of Social and Demographic Variables and Substance Use Variables

* Loadings of .30 or greater.

	Factor 1 Religiosity, drinking and smoking	Factor 2 Prescription drugs	Factor 3 Health, stress, education, sleeping pills, analgesics	Factor 4	Factor 5	Factor 6
M1 (single) (1=yes, 0=else)	–.08	–.04	–.12	–.22	–.14	.67*
M2 (separated/divorced) (1=yes, 0=else)	–.04	.28	.22	–.61*	.07	–.42*
M3 (widowed) (1=yes, 0=else) [residual category–married]	–.02	.07	–.07	.78*	–.01	–.26
L1 (English) (1=yes, 0=else)	.27	.02	.02	.02	.77*	.00
Age	–.20	.12	.21	.52*	.10	–.11
Education	.15	.10	.33*	.02	.28	.58*
Religiosity	–.68*	.21	.12	.10	–.32*	.10
Health	–.01	–.04	.74*	–.06	.05	.23
Stress	–.03	.16	–.58*	–.08	.05	.22
Social support	–.25	–.03	–.01	.02	.61*	–.00
Level of drinking	.63*	.06	–.24	–.07	.01	.23
Use of tranquillizers	–.03	.70*	.02	.02	–.05	–.04
Use of sleeping pills	.14	.44*	–.36*	.29	–.18	.07
Use of antidepressants	.07	.67*	–.13	–.01	.04	.02
Use of narcotic analgesics	–.01	.34*	–.31*	–.03	.26	–.00
Smoking	.62*	.19	–.10	–.01	–.22	–.10

Conclusions

The results from the National Alcohol and Other Drugs Survey tend to be consistent with findings from previous surveys. The special focus of this chapter on older women, however, not only fills a gap in knowledge regarding this subpopulation, but also highlights issues of special relevance to substance use by older women. On the basis of present and previous findings, the following conclusions seem warranted.

- As found by nearly all surveys, older women exhibit the lowest rate of drinking and smoking of any age–gender grouping. Use patterns of younger women suggest that, although future cohorts of older women will increase their use of alcohol, they will continue to be relatively low users. Predictions regarding smoking are less clear because of the convergence of smoking rates among younger men and women.

- Older women, like older men, tend to be higher-frequency, lower-volume drinkers compared with their younger counterparts. There is insufficient data to predict whether the proportion of drinkers at high-risk frequency, high-volume levels will increase among older women; however, if the proportion of current drinkers increases, the relative proportions of all older women at high-risk drinking are likely to increase.

- Older women currently report the lowest rate of instrumental reasons for drinking and the lowest rate of reported problems from drinking among all age–gender groups. Although data from younger women (particularly on problems ever experienced) suggest that future cohorts of older women will experience higher rates of problematic drinking, their relative problem rates compared with other age–gender groupings are likely to remain the lowest. Nevertheless, even small increases in problem rates are likely to have an impact on need for and use of health and social services.

- A more liberal attitude toward substance use may characterize future cohorts of older women, since trends in use patterns indicate that a higher proportion of future cohorts will have had experience with illicit drugs.

- It is a consistent finding across surveys that older women use more prescription drugs than any other age–gender group. In particular, older women have the highest rate of use of psychoactive prescription drugs.

- It is likely that most psychoactive drug use by older women will continue to involve alcohol, sleeping pills and tranquillizers, rather than illicit drugs such as marijuana or cocaine. Therefore, as the population ages, sleeping pills and tranquillizers may well become the most heavily used drugs (excluding alcohol, tobacco and caffeine). Therefore, surveys need to include more accurate and consistent methods of measuring prescribed psychoactive drug use.

- Two dimensions particularly describe factors related to substance use by older women: the association of lower religiosity with more drinking and smoking, and the association among use of various psychoactive prescription drugs (possibly associated with poorer health and higher stress).

The non-problematic style of alcohol use among most older women is a useful topic for future research. Older women drinkers tend to drink very little, have a low rate of problematic drinking (as measured by instrumental reasons for consumption) and report few problems. It may well be that identifying the factors that contribute to light or moderate drinking by older women could have implications for encouraging moderation in the general population of adults. Although older women have consistently demonstrated the lowest rate of alcohol abuse in Canadian and American studies (e.g., Health and Welfare Canada, 1988; Hilton, 1988a, 1988b; Wilsnack, Wilsnack & Klassen, 1984, 1987), the social aspects of this phenomenon have not been studied.

The results regarding general patterns of substance use identified in the factor analysis also have direct implications for future studies of older women. At present, a fairly large proportion of older women are very religious and do not drink or smoke. However, major role changes for women have occurred among those women who have not yet reached age 65. It is uncertain whether the current pattern of greater religiosity and abstinence from alcohol and smoking will continue to characterize future generations of older women.

The dimension showing an association of use of all types of psychoactive drugs needs more attention, particularly among those who tend to be higher users (women and older people). Poor health and stress account for only a small percentage of variance in explaining reported use. Therefore, it is questionable that all prescriptions for psychoactive drugs serve a therapeutic function. In addition, the therapeutic benefit of multiple-use patterns might be questioned. Although the use of a single psychoactive drug may be therapeutic, it is unlikely that the concurrent use of several psychoactive drugs (particularly, sleeping pills, tranquillizers and antidepressants) is therapeutic. Another important consideration is that psychoactive prescription drugs have high dependence potential, and use of such drugs can be risky for older people (Cooper, 1991). With an aging population, more knowledge is needed regarding the factors that determine psychoactive prescription drug use. In addition, we need to know more about levels of use, length of time using, reasons for use, concurrent use of more than one drug and consequences of use. It is possible that the lives of older women are more likely to be impaired by use of tranquillizers and sleeping pills than by use of alcohol.

Finally, we also need to know more about potential response bias by older women regarding questions on alcohol and drug use. Do older people interpret questions in the same way as younger people? Are they able to report use as accurately? What is the effect on prevalence estimates of excluding institutionalized older persons? Do women, especially older women, differentially underreport drinking because of perceived social desirability? Consistency of findings across surveys does not rule out potential systematic bias.

In sum, the low rate of problems related to alcohol use by older women is an important area for future research for at least two reasons: (1) to confirm the accuracy of the low rate of problems and (2) to identify the factors that help maintain moderate drinking. With regard to smoking, we need to know whether the higher rates of use by younger cohorts will result in higher rates by older women. In addition, there is a need for better information on the causes and sequelae of psychoactive drug use by older women.

Finally, longitudinal data are needed, particularly regarding women, to tease apart cohort and aging effects in order to better understand and predict changes in substance use patterns of women as they age.

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Notes

1. This chapter is a slightly revised version of a paper originally published in the *Canadian Journal on Aging*, 14(4), pp. 769–791. A version of this paper was presented at the 18th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society, June 1–5, 1992, Toronto, Canada.

2. The term "former drinkers" is used to refer to those respondents who reported no alcohol consumption during the previous 12 months but who are not lifelong abstainers. As will be described later in this section, the term "former drinker" may not be accurate for many who meet this criterion, especially women.

3. The specific question in the survey was, "In the past 30 days, did you take any of the following medications? (a) Aspirin or similar pain reliever, (b) tranquillizers such as Valium, ... (k) sleeping pills, (l) stomach remedies, laxatives."

4. Because the focus of this paper is on older women, detailed analyses are reported only for this group. Comparative relationships for other age–gender groups are discussed, but detailed results for other groups are not presented.

5. To reduce the number of missing values in the factor analyses, income was excluded from the analyses; those who responded to the question on religiosity as not applicable (as opposed to not responding) were categorized as not very religious; those who rated helpfulness of family and friends as not applicable were coded as 1.5 (between not helpful and somewhat helpful); and those who did not state their education level were classified as having elementary education. With these changes, the component analysis, using listwise deletion of missing cases, included 719 out of the sample of 759 older women.

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Multicultural Influences on Women's Use of Alcohol, Tobacco and Drugs[1]

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Canadian patterns of use of addictive substances are the result of uniquely Canadian historical and social forces, and of international influences due to the cultural diffusion of ideas and the influx of immigrant populations. Cross-cultural influences permeate across national borders as ideas, behaviors and norms spread. In Canada, this process takes a far more concrete form, as the spread of people immigrating to Canada from other parts of the world contributes to the formation of a uniquely Canadian multicultural population.

This paper briefly describes the formation of Canada's current population through the process of emigration from a variety of countries, each with its own different traditions of alcohol and drug use. Some evidence will be presented that these differences persist after immigration to Canada, and that differences continue to be found among persons, and particularly among women, from different ethnic or cultural groups. Finally, the relationship between length of stay of ethnic or cultural groups in Canada and their level of acculturation (the adaptation to and adoption of the societal mainstream norm) will be examined in terms of alcohol and other substance use.

The Formation of Canada's Multicultural Population

Canada's current population is a mosaic of ethnic and cultural groups that have settled here. Although the first wave of immigrants arrived to form Canada's aboriginal population more than 20,000 years ago, it was not until 1608 that planned European (French) settlement

began with Champlain's establishment of a fur-trading fort at Quebec. English settlement began in earnest after the Treaty of Paris (1763), when British troops, consisting largely of Scots, Americans and German-speaking Hessian troops, settled in Canada. After the American Revolution (1776), three-quarters of United Empire Loyalists resettled in the areas now known as Nova Scotia, Prince Edward Island and New Brunswick, and the remainder settled in what became Ontario and Quebec. From 1783 to 1812, "late Loyalists" arrived – pioneer American farmers, German Mennonites from Pennsylvania, and Scottish Highlanders. From 1830 onward, Eastern and Central Canada saw the arrival of Scots, English and, after the potato famine of 1846–54, Irish. German-speaking Mennonites from Southern Russia and Icelanders settled in Manitoba (1874–79), Americans followed the gold rush to British Columbia (1870s) and the Yukon (1897–98), and Chinese workers arrived to build the transcontinental railway (1872–85). Starting at the turn of the century and continuing well into the economic boom of the 1920s, a flow of immigrant farmers from the United States and Europe (Austria, Poland, Russia, Hungary, the Balkans and Italy) settled into the Prairie provinces, primarily Alberta and Saskatchewan. The Second World War was followed by influxes of Europeans, including Germans, Dutch, Hungarians, Polish, Italians, Greeks and others (N.L.N., 1984; W.L.M., 1984). In the 1960s, immigration patterns broadened even further (Dominion Bureau of Statistics, 1958), so that today, the largest percentage of immigrants is from Asia (42 per cent) and from non-European countries (29 per cent) (White, 1990; Swan, Auer, Chénard, dePlaa, deSilva, Palmer, Serjak & Milobar, 1991).

The nature of mainstream Canadian society has been shaped by the contributions of different ethnic and cultural groups, each with its varying beliefs, customs, mores, norms and behaviors. Each cultural group's degree of societal influence is determined by several factors: how long it has been in Canada, its relative proportion in the population, its economic contribution and its political power. However, not all groups have fully amalgamated into the mainstream. Many groups have been in Canada a relatively short time or have maintained a strong sense of cohesion and cultural identification. These groups continue to maintain their own distinctive culture within the mainstream. Non-mainstream cultural norms, beliefs and behaviors specific to each ethnic or cultural group continue to influence daily life for many people in Canada, especially attitudes, opinions and behaviors regarding sexual roles and the use of alcohol, tobacco and drugs.

International Trends in Substance Use

A number of studies have found differences in the use of intoxicants between men and women, as well as between women of one ethnic, cultural or national group and those of another.

An international study conducted under the auspices of the World Health Organization by Joy Moser (1980) was one of the first to systematically document differences between male and female drinking in a country, as well as differences among women of various countries (see Table 7.1). Despite definitional variations from survey to survey, it was possible to identify countries with relatively higher (over 50 per 1,000) or lower (under 10 per 1,000) rates of heavy drinking. Drinking levels of men and women in a country were correlated (r=.67, p<.0005), and women had lower levels of alcohol consumption than men.

International data (see Table 7.2) also showed sex differences in tobacco consumption between men and women in a given country and among women of different countries. For example, large differences between the genders were found in developing countries such as China, Thailand, Indonesia, Malaysia, Tunisia, Nigeria and Bangladesh. Countries that ranked high in terms of male smokers did not necessarily rank high in terms of female smokers. The correlation between men's and women's smoking was weaker (r=.3, p<.05) than that for alcohol.

TABLE 7.1
Rate of Heavy Drinkers or Alcoholics per 1,000 Total of Specified Population Surveyed in Various Countries

Area, Date Surveyed	Rate per 1,000 population		Definition
	Male	Female	
AFRICA			
RHODESIA			
Bulawayo (1970)	20	18	Probable alcoholics
Salisbury (1971)	22	17	Probable alcoholics
AMERICAS			
ARGENTINA	39	0	Alcoholics
Section of Greater Buenos Aires (Lanus) (1975)	120	11	Excessive drinkers
Cordoba (1971)	75	4	Alcoholics
	105	14	Excessive drinkers
Sao Paulo (suburb of Riberao Preto) (1962)	170	104	Excessive drinkers
	136	9	Pathological drinkers
CANADA			
Canada exclusive of Yukon & Northwest Territories Nov.-Dec. 1976	147	34	14 or more drinks in past 7 days
	67	9	More than 28 drinks in past 7 days
March (1978)	139	31	14 or more drinks in past 7 days
Ontario (1969)	50	14	At least 13 oz (about 400 mL) whisky (or equivalent) a day
British Columbia (1978)	190	67	Daily or almost daily users

TABLE 7.1 (cont'd.)
Rate of Heavy Drinkers or Alcoholics per 1,000 Total of Specified Population Surveyed in Various Countries

Area, Date Surveyed	Rate per 1,000 population		Definition
	Male	Female	
CHILE			
Santiago Jan.-May 1954	83	86	Alcoholics: subjects intoxicated daily in preceding year (or at least twice a week on work days) and those who had more than 4 crises a year (each of 2 or more days of repeated drunkenness) with absenteeism of more than one-sixth of working days a year
	283	5	Excessive drinkers: intoxicated 12 or more times during the year, each month, fortnight or week but without serious crises
Greater Santiago	127	4	Alcoholics
	112	8	Alcoholism: inability to stop or abstain while drinking; if doubt, additional indicators: frequency of drunkenness, crises, withdrawal symptoms
	170	12	Excessive drinkers: drunk more than 12 times in one year
JAMAICA			
Kingston (1966)	380	80	From 667 drinks of spirits or 1000 bottles of beer to 1333 drinks of spirits or 2000 bottles of beer a year
PERU			
Lima (1958)	121	34	Alcoholism: including excessive drinkers and addicts
Pachacamac	91	58	Alcoholism
USA (1963)	130	30	Heavy drinkers: medium or large quantities - once a week
USA			
Exclusive of Alaska and Hawaii (Jan. and June 1975)	8-15	3-6	Problem drinkers: 4 or more of 16 symptoms frequently, or 8 or more sometimes
1976	18	3	Heavier drinker
New York (Washington Heights District) (1960-61)	32	9	Alcoholics: specified difficulties due to drinking
New York City (1963)	93	36	Implicative drinking: present or past problem due to drinking; or at least 3 or 4 personal reasons for drinking; or too much drinking with an acknowledged personal reason

TABLE 7.1 (cont'd.)
Rate of Heavy Drinkers or Alcoholics per 1,000 Total of Specified Population Surveyed in Various Countries

Area, Date Surveyed	Rate per 1,000 population		Definition
	Male	Female	
USA (continued)			
Western New York State: Erie and Niagara counties (1975)	390	110	Heavy drinkers: 1 or 2 drinks 3 or more times a day up to 5 or 6 drinks twice a month
Washington County, MD. (1971-74) (1973)	64	4	Alcoholism: index of uncontrolled drinking: 9 questions about harmful behavior associated with alcohol use.
			Quantity-frequency scale, including questions about escape drinking and measures of loss of control.
	260	60	Heavy intake
	203	87	Escape drinking
	128	36	Heavy escape drinking
	64	4	Loss-of-control drinking
San Francisco (1966)	49	18	Excessive drinking (heavy drinking and binge drinking)
	44	23	Possible addiction or coping
	94	40	Any 1 or more of 11 indices
EUROPE			
FINLAND			
(1969)	110	12	> 10 L of 100% ethanol a year
(1976)	120	20	> 10 L of 100% ethanol a year
FRANCE			
(1959)	210	30	"Drunk too much fairly often"
Centre Doria Marseille, cited in France, Inspection Générale des Affaires Sociales (1973)	270	24	3/4 L wine and 1 aperitive a day
GERMANY			
Federal Republic Bremen (1973)	38	26	Alcoholism: WHO (1952) definition and dependence on alcohol Regular daily consumption > 100 mL alcohol
GREAT BRITAIN			
NORTHERN IRELAND			
Borough of Larne (1971)	51	0	Abnormal drinkers according to scale of preoccupation with drinking
IRELAND			
Mullingar in County Westneath (1974)	115	20	Alcoholics

TABLE 7.1 (cont'd.)
Rate of Heavy Drinkers or Alcoholics per 1,000 Total of Specified Population Surveyed in Various Countries

Area, Date Surveyed	Rate per 1,000 population		Definition
	Male	Female	
UNITED KINGDOM			
ENGLAND AND WALES			
Cambridgeshire (1963-64)	6	1	Evidence of regular or periodic heavy drinking between 1961 and 1964, together with evidence of ill-effects attributable to drinking
London suburb (1965)	260	60	Moderate: moderate frequent to heavy infrequent drinking
	140	0	Heavy: at least twice a week, > 6 drinks (54 g ethanol) on usual occasion
London suburb (1972)	61	8	Problem drinkers: 5 or more troubles
London suburb (borough) (1965-66)	9	1	"Labelled" alcoholism: cases reported as having evidenced symptoms of problem drinking 1 April 1965 to 31 March, 1966
SCOTLAND (1972)	740	460	Regular drinkers
	70	0	51 units (459 g 100% ethanol) or more in the week (a unit = the usual measure for one drink of beer, wines or spirits = about 9 g 100% ethanol)
	11	1	"Alcoholics": WHO Definition
ICELAND (1966-67)	1	0	ICD (8th revision) diagnosis. Alcoholism, alcoholic psychosis and drug dependence (nearly all alcoholism). One-year incidence
(1978)	132	18	3 or more of 9 specified symptoms = alcohol abuser
ITALY			
Rome (1958)	490	80	2-8 L wine a week, i.e. 2-9 glasses a day
NORWAY (1962)	200-500	80-310	Regular drinkers (minimum of one type of beverage once a week, 2 types each once a fortnight, 3 types each one in 3 weeks)
SWEDEN (1947)	111	21	Alcohol abusers
SWITZERLAND Valais (1958-59)	116	12	Alcoholics: Jellinek's formula
(1975) (French-and German - speaking Switzerland)	18	2	160 g 100% ethanol a day or more

TABLE 7.1 (cont'd.)
Rate of Heavy Drinkers or Alcoholics per 1,000 Total of Specified Population Surveyed in Various Countries

Area, Date Surveyed	Rate per 1,000 population		Definition
	Male	Female	
ASIA:			
INDIA:			
Punjab (1977)	40	1	Alcohol addicts (based on expressed craving)
Punjab (1978)	583	15	Alcohol users
Punjab	496	0	Alcohol users (0-100 mL ethanol a day)
JAPAN:			
Tokyo	846	528	Drink
Metropolitan Area (1976)	306	36	Drink daily
SRI LANKA (1975)	13	0	Alcoholism, rated moderate or severe: excessive alcohol intake leading to physical, psychological or social harm. Excessive = at least 1/4 bottle spirits (or equivalent) 3 days a week for at least 6 months of the year for 2 years
WESTERN PACIFIC:			
AUSTRALIA			
Sydney Metropolitan area (1968-69)	480	150	Heavy drinkers: at least 1-2 times a month, modal quantity 5 or more drinks on an occasion; at least 3-4 times a week, 5 or more drinks; at least nearly daily 3 or more drinks
Sydney suburb (1971)	266	167	Daily drinking (no amounts specified)
Sydney (1976)	113	16	Every day 6 or more drinks a day (quantity not stated)
Sydney (1963)	320	160	High consumption

Adapted from: Joy Moser, (1980) *Prevention of Alcohol-related Problems. An International Review of Preventive Measures, Policies and Programmes, compiled with the help of contributors from more than 80 countries in the six WHO regions*, Toronto, Canada. Published on behalf of the World Health Organization by the Alcoholism and Drug Addiction Research Foundation (WHO Collaboration Centre for Research and Training on Alcohol and Drug Dependence Problems), pp. 55-70.

TABLE 7.2

International Statistics: Percentage of Adult Smokers by Sex for Selected Years, 1970-1980

	Percentage Who Smoke				
Country or Area	Male	Female	Country or Area	Male	Female
AFRICA			ASIA (cont'd)		
Egypt	40	1	Japan	70	14
Ghana	50	n.a.	Malaysia	56	2
Ivory Coast	24	1	Nepal	87	72
Morocco	93	n.a.	Pakistan	49	5
Nigeria	53	3	Philippines	78	n.a.
Senegal	43	35	Singapore	49	8
Tunisia	58	6	Sri Lanka	48	2
Uganda	33	n.a.	Thailand	70	4
Zambia	63	56	Turkey	50	50
AMERICA, NORTH			EUROPE		
Barbados	10	n.a.	Austria	46	13
Canada	37	29	Belgium	60	50
Cuba	40	n.a.	Czechoslovakia	43	11
Guatemala	36	10	Denmark	68	49
Jamaica	56	14	Finland	60	50
Mexico	45	18	France	70	50
United States	35	32	Germany, Federal Republic of	40	29
			Hungary	45	23
AMERICA, SOUTH			Ireland	49	36
Argentina	58	18	Italy	56	32
Brazil	54	37	Netherlands	57	42
Chile	45	26	Norway	40	34
Columbia	52	18	Poland	63	29
Guyana	48	4	Romania	52	9
Peru	34	7	Spain	66	10
Uruguay	60	32	Sweden	30	30
Venezuela	45	26	Switzerland	50	37
			United Kingdom	38	33
ASIA			Yugoslavia	57	10
Bangladesh	70	20			
Brunei	20	7	OCEANIA		
China	95	1	Australia	37	30
Hong Kong	37	5	New Zealand	35	29
India	66	26	Papua New Guinea	85	80
Indonesia	75	10			
Israel	44	30			

Adapted from: Masironi (Co-ordinator, WHO Program on Smoking and Health), "World Trends in Smoking." Reference paper #1 presented at an ICAA International Workshop on Smoking and Health, Calgary, Alberta, August, 1985. Cited in: M. Adrian, P. Jull, R. Williams (Eds.), *Statistics on Alcohol and Drug Use in Canada and other countries - Volume II: Statistics on Drug Use, Data Available by 1988* (Toronto: Alcoholism and Drug Addiction Research Foundation, 1989).

Substance Use Patterns in Ethnic or Cultural Minorities

Studies of substance use by ethnic or cultural minorities have found differences in consumption between men and women and among women of different ethnic groups, as defined in each study in countries with mixed ethnic populations. (Please note: the terminology used in this chapter is as given in each of the studies cited.)

Studies in the United States have found differences in the drinking patterns of men and women, with women generally consuming less than men, as documented in studies of American Indians (May, 1982); blacks (Harper, 1989); whites, blacks and Orientals (Klatsky, Siegelaub, Landy & Friedman, 1983); Chinese (Yu & Liu 1986-87); whites, Orientals, American Indians, blacks, West Indians and Hispanics (Welte & Barnes 1987); Europeans, Chinese, Filipinos, Hawaiians and Japanese (Danko, Johnson, Nagoshi, Yuen, Gidley & Ahn, 1988); and Southeast Asians (Laotians, Vietnamese, Cambodians, and persons from Hong Kong) (Community University Health Care Centre, University of Minnesota, undated).

Differences in alcohol consumption among women of different ethnic groups were found in studies conducted in (1) Israel, of native-born Israelis, Jews, North Africans, Asians and Europeans (Baras, Harlap & Eisenberg, 1984); and (2) the United States, of whites, blacks and Orientals (Klatsky, Siegelaub, Landy & Friedman, 1983); blacks, Hispanics, Indians, Asians and whites (Leland, 1984); whites, Orientals, American Indians, blacks, West Indians and Hispanics (Welte & Barnes, 1987); Hispanics (Caetano, 1987); U.S.-born Mexican-American women, Mexican-born women, and Mexican-born women who immigrated to the United States (Caetano, 1988); and on Afro-Caribbeans, Asians, Europeans and Orientals (Waterson & Murray-Lyon, 1989).

Finally, a number of studies found differences in substance use patterns between immigrant women and non-immigrant women within a specific ethnic or cultural group, with differences apparently due to the acculturation process. A number of studies suggested that an increase in women's drinking was a mechanism for coping with the tensions associated with changing cultures. Holck and his colleagues (1984) interpreted the increase in drinking in Mexican-American women assimilated into the Anglo-American cultural experience as stemming from the tension created when trying to adapt to the values and norms of the American culture while maintaining the traditional values that form their heritage. Similarly, Yu and Liu (1986–87) considered that increases in drinking among Chinese women in the United States stemmed from rapid social change, rising economic prosperity, the adoption of "male" roles in the workplace, and changes in social norms and family relationships. Yu and Liu held that the women's drinking served as a means of coping with stress and managing tensions resulting from discontinuities in social values. Other studies recognized that the pattern of alcohol consumption was specific to a culture: as immigrants adopted the behavior patterns of the new culture in which they lived, they also adopted some of the alcohol consumption patterns of their new country. Caetano and Mora (1986) and Caetano (1987) reported that the pattern of drinking in Hispanic women was positively related to their level of acculturation to American society. Caetano (1988) found that "Mexican-American women born in the USA had lower rates of abstention and higher rates of frequent high maximum drinking than women born in Mexico" (Caetano, 1988:59). Blane (1977) found that, with successive generations, the tradition of taking wine with

meals dissipated in the Italian-American family. By the third generation, the custom had virtually disappeared and the women had largely adapted to American women's drinking practices.

Substance Use Patterns in Ethnic or Cultural Groups in Canada

Canadian data on substance use by women of specific ethnic or cultural groups, although much scarcer, have also shown differences in substance use between the sexes in different ethnocultural groups. Studies using key informants for selected ethnic communities in Toronto have found that drinking and intoxication are less acceptable and less common among women than men in a number of ethnic or cultural groups. In the Greek community, for example, "it is far more acceptable for men to drink than women. It is also permissible for men to become slightly intoxicated" (Kendall, 1989c:6). In the Sri Lankan Tamil community, alcohol consumption "is a long rooted tradition for Tamil males. ... Excessive drinking by males was accepted as was alcoholism" (Kendall, 1989e:16). In the Caribbean community, men "drink more heavily than women ... except on weekends and special festivities. ... Women tend to be social drinkers" (Kendall, 1989d:17). However, in the native Canadian community, substance abuse of alcohol was reported in young indigents, both male and female (Kendall, 1989a). An alcohol and drug education needs assessment conducted in British Columbia (Alcohol and Drug Education Service, 1989) also found gender differences in consumption patterns of persons from different ethnic groups. Alcohol consumption and drunkenness were found to be less acceptable for women than for men, and female consumption was lower than male consumption in the Chinese, Indo-Canadian, Latin-American and Vietnamese communities. Another study (Legge & Sherlock, 1990-91), also conducted in British Columbia, surveyed 205 persons in ethnic communities about their alcohol use. It found that alcohol use by women was most accepted by the Chinese community (70 per cent acceptance), which had the second highest level of perceived drinking among women (93 per cent). The Latin-American community had a mid-level of acceptance (36 per cent), but the highest level of perceived drinking among women (94 per cent). Finally, the Indo-Pakistani community had the lowest level of both acceptance (10 per cent) and perceived drinking among women (57 per cent).

Perceptions of the social meaning of alcohol also differ for different ethnic groups in Canada. The Greek community in Toronto considers it usual to have wine with their main meal (Kendall, 1989c). Similarly, the Italian community in Montreal considers wine a food and an integral part of the meal (Cardinal, 1986). In Toronto's Italian community, folk wisdom recommends a glass of wine with each meal: "good wine makes good blood" (Kendall, 1989b:21). Reasons for drinking given by the Chinese, Indo-Canadian, Latin-American and Vietnamese communities in British Columbia (Alcohol and Drug Education Service, 1989) include using alcohol "to enhance social relationships," "to celebrate special occasions," and "to entertain," as well as for "stress reduction." Stress reduction was the most frequently cited reason for drinking reported by Latin-American and Indo-Canadian women. According to Indo-Canadian women, alcohol is used because it is a "status symbol"; according to Chinese women, it is used for "health" and "medicinal purposes"; and according

to members of the Latin-American community, it is used for reasons involving "machismo." Legge and Sherlock (1990–91) found that among the Chinese, Latin-American and Indo-Pakistani communities in British Columbia, more than half identified "family problems," "to forget problems" and "to handle frustrations" as reasons for drinking; less than 20 per cent mentioned "cultural adjustment difficulties."

As was the case for alcohol, smoking was found to be more acceptable for men than for women in some communities in Toronto. In the Sri Lankan Tamil community, "only males smoke ... . Women rarely smoke but, along with the males, chew a concoction of betel leaf, arecanut, tobacco, and slaked lime, which provides a mild stimulation" (Kendall 1989e:16). In the Caribbean community, "there are more taboos associated with smoking, particularly for women. Quite a few men smoke, but smoking by women is frowned on. In the Caribbean, older women may smoke, growing their own tobacco and smoking a pipe" (Kendall, 1989d:17). In the native Canadian community, however, both men and women were involved in the use of tobacco. Tobacco is highly valued in this community, being considered "the most sacred plant used in traditional ceremonies." It is "customary to give a gift of tobacco to a medicine man/woman prior to consulting him/her on spiritual and other matters. ... Both sexes participate in the Pipe Ceremony ... and both men and women will smoke the Pipe when it is passed around. However, women undergoing menstruation do not handle the Pipe" (Kendall, 1989a:22).

The Alcohol and Drug Education Needs Assessment study, conducted in communities in British Columbia, found that both the Chinese and Indo-Canadian communities expressed concern about women's use of sedatives (Alcohol and Drug Education Service, 1989). In Toronto's native Canadian community, both sexes are reported to be involved in abuse of legal and illegal drugs (Kendall, 1989a).

The Dynamics of Ethnocultural Differences in Substance Use

Evidence from international data and from studies of selected ethnic groups in given geographical areas would seem to support the existence of (1) gender differences in substance use in many different ethnic groups, (2) differences in substance use by women of different ethnic groups within a given jurisdiction or geographical territory and (3) differences in consumption patterns between women who had immigrated and women born in the country studied.

Previous studies of substance use patterns among women of different ethnic groups may be critiqued on a number of points. First and foremost, there are few studies devoted solely to women. Frequently, information about women of different ethnic groups is a spin-off of studies that either do not distinguish between the genders or studies that have males as the primary focus. Of those studies that contain information about substance use among women, most focus on ethnic or cultural groups that do not compose a large part of the Canadian population. Particularly in the American studies, the classification system used for ethnic groups does not readily correspond to Canadian ethnocultural groups. Of the four studies the authors were able to identify that addressed substance use among women of different ethnocultural populations in Canada, all were conducted in narrowly defined geographical areas, and only one contained quantitative data.

Hypothesis

Earlier studies have led the authors to hypothesize that when people immigrate to a new country, they continue to exhibit behavior patterns similar to those of their country of origin. Groups of people that have arrived more recently than others would show the greatest differences in behavior from the mainstream, including differences in substance use patterns. Differences would be most evident in the first years following their immigration, before they had adopted the culture of the mainstream society. The persistence of "old-world" patterns of substance use in Canada is determined by the persistence of old-world belief systems regarding men's and women's consumption of alcohol, tobacco and drugs (including beliefs about what is normal and appropriate for each gender). Hence, women from ethnic or cultural groups that have high levels of consumption in their countries of origin would tend to continue high levels of consumption in Canada. Those from countries with low levels of consumption would continue low levels of consumption in Canada. The overall result is that consumption levels of women who identify themselves as ethnic or multicultural would follow old-world patterns and would differ from the Canadian mainstream pattern, exceeding or falling below the mainstream level.

This chapter will use quantitative descriptive information from a national survey of alcohol and drug use in Canada to examine the differences in consumption patterns between women of different ethnic groups and the Canadian mainstream pattern. It will also examine these patterns in relationship to the level of acculturation of specific ethnic or cultural groups as measured by their length of stay in Canada.

Data Source

Detailed quantitative information on substance use of Canadian women of different ethnic or cultural groups became available from the National Alcohol and Drug Survey (NADS) conducted in March 1989 by Statistics Canada, which did all data collection, including interviews, on behalf of Health and Welfare Canada. The federal government staff subsequently made the data available for analysis by researchers across the country. In total, 11,634 adult Canadians aged 15 and over (51 per cent or 5,945 were women) from 10 provinces were surveyed, excluding residents of institutions such as prisons and hospitals. The data were collected through telephone interviews with households selected via random digit-dialling methods so that most Canadian households were equally likely to be selected. Of those contacted, 79 per cent responded. The data were weighted to take into account households without phones, persons who did not respond, multiple telephones in households, the number of persons in the household, census projection counts for the provinces, and the age and sex of the population. Wherever possible, the survey adopted standard questions that had proven to be effective in previous research. Conforming to the *Statistics Act*, all respondents were given assurances of anonymity and confidentiality. The level of response was greater than 99 per cent for most questions (Eliany et al., 1990). All respondents to a question were included in the analysis. (For a more detailed discussion of the NADS survey, see Chapter 15.)

Ethnic Composition of NADS Female Population

Only female respondents were considered in our analysis. Information on each

respondent's ethnic or cultural group was obtained from the preset categories of responses to the question, "Which ethnic or cultural group do you belong to?" These categories correspond to groups in the Census of Canada, with the addition of the category "Canadian," which is not traditionally used in the census. "Jewish" is an ethnic category in the census and was so used in the NADS. There was no category for native Canadian Indians or Inuit in the NADS. Because of sample size limitations, some ethnocultural groups were combined in this analysis.

Although there has been recent criticism of the concepts and typologies of race, ethnicity and culture in the substance use field (Cheung, 1989, 1990/91a,b, in press), our analysis was limited to the predetermined ethnic or cultural group information elicited by the NADS. For purposes of this chapter, the terms "ethnic or cultural group," "ethnocultural group" and "ethnic or cultural community" are used interchangeably.

Results

Ethnocultural Composition of the Population

Most women surveyed in the NADS described themselves as belonging to the "Canadian" ethnic or cultural group (42 per cent), with 16 per cent French, 12 per cent English (British), five per cent German/Dutch, five per cent Irish, five per cent Scottish, three per cent Ukrainian/Polish, three per cent Italian/Portuguese and nine per cent "Other" (Chinese, Jews and others).

Drug Use

The survey provided information on 110 variables measuring different aspects of substance use behaviors such as consumption of alcohol, tobacco, and legal and illegal drugs, including frequency of consumption, quantities consumed and circumstances surrounding consumption (e.g., "at home," "with friends," etc.), questions on drug-taking behavior, such as drug type, quantity, frequency, drinking or drug-taking circumstances, beverage preference, reasons for drinking or not drinking, opinions regarding appropriate drinking or drug-taking behavior. Each variable corresponds to the response options to a substance use question. A dichotomous yes/no response question, such as "Have you ever been a cigarette smoker?," would count as one variable. A quantitative response question, such as "How old were you when you started smoking?," would also count as one variable. A question comprising four subquestions with dichotomous yes/no responses such as "In the past 12 months, have you taken a drink to please [(a) your spouse/partner, (b) a family friend or relative, (c) a friend, (d) a co-worker] although you did not feel like drinking?," would count as four variables. In total, 110 substance use variables were identified.

Method of Analysis

A composite index number method was used to quantify the degree of similarity or difference between each ethnocultural group's substance use and the national average.

Composite index numbers, such as the Consumer Price Index (CPI), combine different measures obtained for a number of variables in order to construct a single composite index number. The composite index number is then used to compare the behavior of different groups using a single composite index number measurement for each group. Composite index numbers combine numerous

detailed measurements on different aspects of that which is to be measured. The intent in constructing composite index numbers is to capture as full a range of items to be measured as possible. In general, an index combines as wide an array of measures of a particular phenomenon as possible. The larger the number of items included in the index number, the more robust the index because it is less subject to the effects of random fluctuations in a particular variable as would happen if the index incorporated only a small number of variables. This is because the variance of the index number is the weighted sum of the variance and covariance of the components. In this study, the availability of 110 variables for incorporation into the composite index permits the construction of a relatively robust measure of substance use. The grouping of variables into the categories shown in Table 7.1 is used for purposes of presentation only and is intended to convey the gist of the measures in our index number. The order or the grouping of variables has no impact on the calculation of the actual index number itself.

Variables measuring substance use for women of different ethnic or cultural groups were compared to the national average using a *t*-test of the equality of percentages (Sokal & Rohlf, 1969) with differences significant at least at the .05 level (in most cases differences were significant at the .00005 level).[2]

Substance use variables were grouped into categories for ease of presentation of the results of the composite index number analysis. For example, the behavior category "Reasons to Drink" comprised six variables consisting of (1) to be sociable, (2) to add to enjoyment of meals, (3) to feel good, (4) to help relax, (5) to forget worries and (6) to feel less inhibited. On a national average, 73 per cent of women in Canada said they drank to be sociable. The percentage of French-Canadian women who said they drank to be sociable was statistically significantly *less* than the national average, and, on this variable, they would be scored as differing from the national average. For the category "Reasons to Drink," French-Canadian women differed from the national average for three variables, and the number of differences for this category would be scored as 3. These differences were then summed across all categories for French-Canadian women whose substance use differed from the national average for 31 per cent of all variables.

The NADS contains more questions on alcohol than on tobacco and drugs. Characterizing women's substance use in terms of the 110 NADS variables gives great weight to alcohol use, which is consistent with the fact that more women use alcohol than tobacco or drugs. However, more women use tobacco than either illegal drugs or legal psychoactive drugs, while the NADS contains fewer questions about tobacco than about other drugs. One may be tempted to correct this by assigning different weights to the different substances and substance use variables, but it is difficult to determine what relative weight to give to each variable. In such cases it is considered sound statistical practice to assign a value of unity to all variables (Hellwig, 1974; Adrian, 1983), as was done in this analysis.

Ethnocultural Patterns of Substance Use Behavior

Overall, French-Canadian women had more variables that showed less use of alcohol and drugs and identified fewer circumstances for alcohol use than the national average. Of women from the British Isles, English-Canadian women

had less drug use than the national average; Scottish-Canadian women had higher use and identified more circumstances for use of alcohol, but lower use and fewer use circumstances for drugs, especially illegal drugs, than the national average; finally, Irish-Canadian women scored higher than the national average for both alcohol and drug use and for circumstances and reasons to use alcohol. German/Dutch-Canadian women also had more use of alcohol and drugs, and they identified more circumstances when it was appropriate to use alcohol than the national average. Ukrainian/Polish-Canadian women had higher use of alcohol and gave more reasons and circumstances for its use, but they used fewer drugs and less tobacco than average. Italian/Portuguese-Canadian women had less use of alcohol and gave fewer reasons and circumstances for its use; they had less use of illegal drugs, but more of legal drugs and tobacco than average. Finally, "Other"-Canadian women had less use of alcohol and identified fewer reasons and circumstances for its use; they had less use of tobacco or legal drugs, but more use of illegal drugs.

Relationship between Ethnocultural Groups and Drug Use Patterns

We examined the extent to which women of nine different Canadian ethnocultural groups had substance use variables that were similar or different from the national average (Table 7.3). Women who identified their ethnic or cultural group as "Canadian" differed least from the national average in their substance use, differing in only five out of 110 variables (five per cent differences). The Moderately Low range (roughly 30 per cent to 40 per cent differences from the national average) included French-Canadian women (31 per cent differences and women from the British Isles: English-Canadians (28 per cent), Scottish-Canadian (40 per cent), and Irish-Canadian (37 per cent). The Moderately High range (40 per cent to 50 per cent differences from the national average)included German/Dutch-Canadian women (45 per cent), Ukrainian/Polish-Canadian (48 per cent), and "Other"-Canadian women (50 per cent). Finally, the Italian/Portuguese-Canadian women fell in the High range, as they differed in 67 per cent of the variables from the national average.

To some extent, one can relate the level at which an ethnic or cultural group differs from the national average to the length of time that a particular group has been in Canada, as measured by the date of the first major influx and the succeeding waves of migration of that ethnic or cultural group to Canada (Table 7.4). Women of ethnic groups who fall in the Moderately Low range of difference from the national average belong to ethnic or cultural groups that have been present in Canada for more than a century. Thus, French-Canadian women generally trace their descent from the earliest period of colonization by the French from 1608 to 1763. English and Scottish migration to Canada also stems from the early colonization period, having begun after 1763 with a subsequent large wave of immigrants of the 1830s. The Irish began to arrive after the 1830s, with a large wave during the potato famine era of 1846 to 1856 (N.L.N., 1984; W.L.M., 1984).

TABLE 7.3

Differences in Substance Use for Women of Selected Ethnic or Cultural Groups in Relationship to the National Average Canada, 1989 (NADS)

Type of Behaviour	Number of options	Number of Differences by Ethnic Group								
		Canadian	French	English	German/ Dutch	Scottish	Irish	Ukrainian/ Polish	Italian/ Portuguese	Other
ALCOHOL										
Frequency of alcohol consumption	7	1	2	1	3	3	2	3	4	4
Amount of alcohol consumed in specified circumstances	14	0	2	5	3	3	2	3	8	6
Drinking circumstances	18	0	4	1	4	5	2	6	13	11
Beverage preference	7	0	5	0	2	3	2	3	3	1
Reasons to drink	6	0	3	2	0	4	3	2	2	2
Reasons not to drink	12	1	6	3	9	4	4	9		
Opinions about circumstances when it's okay to drink until you feel the effects or are drunk	8	0	2	3	5	1	4	4	3	2
TOBACCO	4	0	0	2	1	2	1	2	3	3
ILLICIT DRUGS										
Use of drugs (except marijuana)	4	2	1	1	2	3	3	2	2	3
Use of marijuana	3	0	0	3	3	1	2	1	3	2
Circumstances surrounding use of marijuana	17	1	5	8	13	13	12	12	16	11
LEGAL DRUGS										
Type of drugs	5	0	3	0	3	0	2	3	4	2
With doctors order or prescription	5	1	2	2	2	2	2	3	4	4
TOTAL NUMBER OF DIFFERENCES	110	6	35	31	50	44	41	53	74	54
% Differences from National Average for each ethnic group	N.A.	5	31	28	45	40	37	48	67	50

TABLE 7.4

Relationship between Dates of Major Wave(s) of Immigration to Canada of Specified Ethnic or Cultural Groups and Level of Differences from the Mainstream Substance Use Pattern Canada, 1989

Ethnic Group in NADS Sample	Approximate date of first and/or major wave(s) of immigration	Proportion of NADS sample	% Differences in substance use traits between each ethnic group and the national average	Level of difference from the national average
Canadian	?	42.3	5	Low
French	1608-1763	16.3	31	Moderately - low
English	1763-1830s	11.8	28	Moderately - low
Scottish	1763-1830s	4.6	40	Moderately - low
Irish	1830s-1846	4.7	37	Moderately - low
German/Dutch	1763-1874-1945	5.0	45	Moderately - high
Ukrainian/Polish	1874-1896-1945	3.4	48	Moderately - high
Other: Chinese	1872-1960s	8.7	50	Moderately - high
Jewish	1896-1945			
Other	?			
Italian/Portuguese	1896-1945	3.0	67	High

Those ethnic groups having a Moderately High level of differences relative to the national average consist of German/Dutch-, Ukrainian/Polish-, and "Other"-Canadian women. Germans began arriving with King George III's Hessian troops after 1763, followed by a wave of German-speaking Mennonites from Russia in 1874, and a wave of German and Dutch people after 1945. Because of the large waves of immigrants in the late nineteenth and mid-twentieth centuries, the German/Dutch group was considered to be a later arrival than the English, Scottish, or Irish. Ukrainians arrived in two main waves of immigration from Russia, in 1874 and in 1896. The Polish began arriving at the turn of the century and after the Second World War. "Other"-Canadians comprise Jewish, Chinese and others. Jewish Canadians arrived in several waves, first at the turn of the century and then after the Second World War. A very limited number of Chinese first came with the building of the railroad in 1872, but the largest numbers followed the liberalization of Canada's immigration policies after the 1960s (N.L.N., 1984; W.L.M., 1984). The Moderately High group thus comprises a small proportion of some people who arrived as early as 1763, but who, for the great majority, had major influxes in the mid-nineteenth century, at the turn of the century, and following the Second World War (see also Neville and Kornberg, 1985; Halli et al., 1990; Richmond, 1988).

Italian/Portuguese-Canadian women make up those in the High range of differences in substance use relative to the national average. In comparison to other groups in this study, Italians and Portuguese are more recently arrived, with some immigration at the turn of the century but with the heaviest influx after the Second World War.

In a general sense, there would appear to be a relationship between how long an ethnic or cultural group has been in Canada and the extent to which it differs from the national average. Those who have been in Canada longest have a substance use pattern closest to the national average, and those who have been here for the shortest time have a pattern of substance use that differs most from the national average.

Ethnocultural groups that have been in Canada longer make up a larger share of the Canadian population, and the size of the responding ethnocultural group may influence the national average, since the national average is weighted by the relative size of its component ethnocultural groups. A multiple regression analysis (Hendry, 1989) of the effects of period of arrival and/or major wave of immigration of an ethnic group into Canada and current size of each ethnocultural group relative to the total population in our survey showed that the effect of ethnocultural group size was not statistically significant (b=–.08, t=–.14, p=N.S.), whereas the time of arrival of an ethnocultural group into Canada was highly significant (b=+4.58, t=+4.02, p<.01) in an equation that explained 86.6 per cent of the variance (adjusted R^2=.866, F[2,5]=16.17, .01<p<.005).

Discussion

Our findings indicate that there is a relationship between the period of time an ethnocultural group has been in Canada and the extent to which its female average of substance use corresponds to the national average. Women of ethnocultural groups that have been in Canada the longest are those whose substance use is closest to the national average, and women from groups

that have been here for the shortest time are those whose substance use differs most from the national average.

The situation is not so clear cut for those women who call themselves "Canadian," since it is not possible to determine who they are and when they or their ancestors first arrived in Canada. It has been claimed that those who identify themselves ethnically as "Canadian" have been in Canada so long that they no longer know to which ancestral group they may belong. Or, parentage may be so mixed and the hyphenated-Canadian allegiance so complex (e.g., "French-English-Scottish-Cree-Belgian-Polish-Italian-Jamaican-Malaysian-Canadian") that it is difficult to select a particular ethnic or cultural group to which one feels one belongs. Hence, it is much more difficult for some people to give any answer but "Canadian" to demographic ethnic questions on surveys. Finally, the "Canadian" ethnic or cultural group may include people who are relatively recent immigrants, but who, for political or emotional reasons, do not wish to be considered as anything but "Canadian."

The "Canadian" group makes up almost half (42 per cent) of the NADS sample and is by far the largest single component. The national average is the mathematical weighted average of the values for each of its component ethnic groups. The "Canadian" group would, *ipso facto*, have a large impact in determining the national pattern. However, the national average is not simply a reflection of the prevailing "Canadian" average, since the "Canadian" group does differ from the national average with regard to certain substance use variables, such as those concerning illegal drugs. Moreover, the "Canadian" group differs in its composition from the national sample. "Canadians" are less likely to speak English at home (67 per cent vs. 71 per cent nationally) and more likely to speak French (33 per cent vs. 25 per cent nationally). Unlike the national sample, none in the "Canadian" group speak German, Italian or Chinese at home, and only 0.2 per cent speak other languages (vs. 2.7 per cent nationally).

Lack of understanding of the meaning of certain questions in English and French – our two official languages – may influence the answers of those persons whose primary language is neither English nor French. Of Dutch/German-Canadian women, 7 per cent report that they speak neither English nor French at home, and this figure rises to 8 per cent for Ukrainian/Polish-Canadian women, 21 per cent for Italian/Portuguese-Canadian women, and 26 per cent for "Other"-Canadian women. It is possible that some women may have misunderstood the questions, and that the type of misunderstanding may be different in each different ethnic or cultural group. Hence, some of the interethnic differences may be due to language differences rather than to differences in behavior in the different ethnic or cultural groups. However, women who do not speak one of Canada's official languages at home may include women who have an adequate command of one, or both, official languages, at a level sufficient to function in Canadian society. Certainly the majority of Italian/Portuguese-, Ukrainian/Polish- and "Other"-Canadian women work, many in industries that require public contact and the use of at least one of the official languages. There is no evidence that there are sufficient differences in the language skills of women who do or do not speak one of the survey languages (English or French) at home to preclude them from answering substance use questions.

Lack of clarity in the meaning of specific questions may also have an impact on the NADS results. This is particularly likely in the case of legal or prescription psychoactive drugs. Only 75 per cent of women in this survey said they used narcotics such as codeine, Demerol, or morphine on doctor's orders. This may be due, in part, to the fact that this category contains codeine. Analgesics containing eight milligrams of codeine or less, such as 222 or Tylenol with codeine, are available as over-the-counter products in Canada and do not require a physician's prescription. Again, that only 53 per cent of women said they used "diet pills" or stimulants on doctor's orders may be due to the popular notion of what constitutes a "diet pill" or "stimulant." The category of "diet pills" may include not only amphetamine-like stimulants but also diet aids that contain primarily vitamin preparations available over the counter. A number of over-the-counter preparations contain caffeine and other non-prescription compounds that have a stimulant "pick-me-up" effect. In the popular imagination, these are construed as "diet pills" or "stimulants" which, in reality, are non-prescription, over-the-counter preparations which do not require doctor's orders (J.A. Marshman, personal communication, July 1991).

That French-Canadian and Italian/Portuguese-Canadian women report less use of alcohol and drugs than the national average may appear initially surprising in view of the fact that France and Italy have among the highest per capita consumption rates of alcohol in the world, mostly in the form of wine (Adrian et al., 1989, Table 126). However, Quebec, the province in which most French-Canadians live, has one of the lowest per capita consumptions in Canada, mostly in the form of beer (Adrian et al., 1989, Tables 9 and 11). These differences between modern France and French Canada may be due to the fact that most French immigration into Canada occurred more than two centuries ago. Another possibility is related to the degree of gender differences in substance use in different countries. These gender differences may be greater or smaller depending on the country. Since many alcohol studies have traditionally been done on males, who generally account for much of the substance use, our traditional view of typical substance use in a country may be more accurate for males than for females for countries with large gender differences. An early study by Moser (1980), reanalyzed by Adrian et al. (in press), found that men in France and Italy had six to 11 times the rate of high alcohol consumption that women did, in contrast to countries like Germany, where the ratio was only 1.4:1. Hence, the traditional view of France or Italy as "wet" countries may be more accurate for men than for women; and French-Canadian and Italian/Portuguese-Canadian women's lesser use of alcohol and drugs, and fewer reasons and circumstances for substance use, may reflect French and Italian women's having a "dryer" attitude than their men.

Conclusion

Alcohol, tobacco and drug use behavior was found to differ among women of various ethnocultural groups. Further, each ethnocultural group was found to differ from the national average. The extent of differences between the national average and each ethnocultural group was related to the period of arrival and the length of time that an ethnocultural group has lived in Canada.

Studies of social integration, cultural identity and acculturation of ethnocultural groups to the mainstream usually consider a variety of psychological and social characteristics: language spoken, religion, education, employment, occupation and other factors. These characteristics are measured by psychological tests of beliefs, opinions, ideals, attitudes and behaviors. This study demonstrates that specific measurable substance use behavior can also be associated with specific ethnocultural groups. The degree of similarity or difference between each ethnocultural group and the mainstream national average, for behavior relating to alcohol, tobacco and drug use, can be used to measure the degree of social integration of each ethnocultural group and the degree of acculturation of women of specific ethnocultural groups into mainstream Canadian society.

A number of studies have shown that immigrant groups experience stress as a result of moving to a different culture, and that their alcohol and drug use increases as a way of dealing with stress (Yu & Liu, 1986–87; Cheung, 1990–91), although only 20 per cent of immigrants in the Legge and Sherlock (1990–91) study specifically cite cultural tensions as the reason for using alcohol. The NADS data have no provision for respondents to indicate if cultural tensions provoke them to drink or take drugs.

Studies have also shown that substance use among immigrants may be greater in comparison to that of people in their countries of origin and, in some cases, to that of their adopted country (Caetano & Mora, 1986; Caetano, 1987, 1988). The NADS data do not allow researchers to determine whether immigrants consume more substances than the average in their countries of origin, since the NADS contains no information on place of birth or immigrant status. There are also no available data comparable to the NADS for women in the countries of origin of ethnocultural women in Canada.

This analysis found that differences in substance use patterns among women of different ethnocultural groups in Canada can vary from the mainstream substance use patterns in either direction, being either higher *and* lower than the mainstream, depending on the type of substance and the women's ethnocultural group.

This analysis represents one of the first systematic analyses of its kind to be conducted in Canada. In its first stage, the pattern of substance use behavior was described for each of the ethnocultural groups surveyed in the NADS. Further analyses are needed to examine the circumstances surrounding normative substance use behavior in the different countries of origin of the ethnocultural groups surveyed in the NADS. To what extent does the persistent memory of old-world behavioral patterns continue to influence the behaviors of members of ethnocultural groups in Canada? Further study is needed to determine the influence of these factors.

Differences in behavior and attitudes toward the use of addictive substances for women of different ethnic or cultural groups have important implications for public health promotion and disease prevention programs. A general program developed to reduce the consumption of alcohol, tobacco and drugs may be inapplicable or inappropriate for women of specific ethnocultural groups. For example, this study's data contradict the traditional data showing high alcohol consumption among the French, Italian or Portuguese (Adrian, Jull & Williams, 1989), since French-Canadian and Italian/Portuguese-Canadian women in the NADS sample reported lower alco-

hol use than average. Programs to reduce alcohol use in these groups might therefore be less cost effective than programs directed toward German/Dutch-Canadian or Ukrainian/Polish-Canadian women, who have higher alcohol use. Similarly, programs aimed at illegal drug use among Italian/Portuguese-Canadian women, focusing on cocaine/crack or heroin; among Ukrainian/Polish-Canadian women, focusing on speed/amphetamines and heroin; and among Irish-Canadian women, focusing on LSD/acid and speed/amphetamines may also be socially beneficial. Equally beneficial might be programs directed at Italian/Portuguese-Canadian women, with the goal of encouraging more of them to seek a physician's advice before using legal psychoactive drugs. Targeted programs with a well-defined focus are cheaper to devise and transmit than broad-based programs with a wide distribution. They may also be more effective in preventing or reducing substance-abuse problems in specific ethnic and cultural groups.

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Notes

1. A preliminary version of this chapter was published in *The International Journal of the Addictions, 30*(6), pp. 699–734 (1995).

2. In tables where the national average exceeds five per cent, percentage differences are significant at the p=.00005 level. In most cases, percentage differences between ethnic groups were shown if they exceeded three percentage points. When the national average was less than five per cent, the level of significance in differences between ethnic groups is at the p=.05 level.

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CHAPTER 8

Canadian Indigenous Women and Substance Use

Kim Scott

Introduction

Census data indicate that a minimum of 711,720 Canadians claim indigenous origins.[1] This represents about three per cent of the Canadian population, with 50.9 per cent being female (Statistics Canada, 1989). Members of Canada's indigenous groups are diverse, speaking 10 major languages and 58 different dialects, and have varied levels of contact with the Euro-Christian population. Indigenous groups in Canada are self-identified as Métis, Inuit and Indian.[2] There are roughly 600 federally recognized communities, with approximately 50 per cent of the total indigenous population residing on Crown lands. Unfortunately, much of the available data focuses on Indian populations only. Indian communities are subject to the provisions of the *Indian Act* (which was also used as a legislative model for acts passed under South Africa's former regime of apartheid). They range in population and structure from virtual air-station outposts with 50 people, to urban centres with 6,000 or more.

The National Alcohol and Other Drug Survey (NADS) contains no specific information about indigenous persons. Thus, data from other sources must be used if we are to understand the special nature of substance abuse among indigenous women. This chapter will first present some background information on indigenous women's lives before specifically addressing the issue of substance use among them.

Background: The Indigenous Canadian Population

The Indian population is younger than Canada's average by about 10 years for both sexes, owing to decreased life expectancy and a higher fertility rate (Assembly of First Nations [AFN], 1988; Statistics Canada, 1989; Department of Indian and Northern Affairs [DINA], 1981; Health and Welfare Canada [HWC], 1986). Canadian Indians are at substantially greater risk than other Canadians for every physical illness except cancer, and for *all* social distresses (HWC, 1986; DINA, 1981; AFN, 1988; Lithwick, Schiff & Vernon, 1986; Native Women's Association of Canada [NWAC], 1981; Wilson-Smith, Wood & Burke, 1990; Lafontaine, 1985, for the National Association of Friendship Centres [NAFC]; Statistics Canada, 1989).

Community unemployment ranges from 10 per cent to 98 per cent. Less than 50 per cent of all households have central heating, and 40 per cent have no indoor bathroom (DINA, 1981; Wilson-Smith, Wood & Burke, 1990). Seventy per cent of respondents claiming only indigenous origins have not completed high school (Statistics Canada, 1989).

There have been noted increases in the number of indigenous nuclear families (in contrast to the traditional extended family), divorces, births outside marriage, child wardships, single-parent families, and adoptions of indigenous children both within the community and by Euro-Christian families (DINA, 1981; Layne, 1984; Fiddler, 1985; Ontario Native Women's Association [ONWA], 1989).

Communicable disease control and overall health status have improved in the last couple of decades (HWC, 1986; Layne, 1984). However, Indian groups still show higher age-standardized death rates for a variety of infectious and chronic diseases, as well as for injury and poisoning (HWC, 1986). In most cases, the risk of death by specific cause is two to four times greater in the Indian population than in the rest of Canada.

Within this context – which both contributes to addiction and is exacerbated by it – stands "citizen minus": the indigenous woman. In addition to facing elevated risks of disease and social distress, she is more likely than her male counterpart to be beaten by her partner (ONWA, 1989; Graveline, 1986); to be a single parent, a survivor of incest or sexual abuse, the target of a youth protection order (Layne, 1984; DINA, 1981) and a victim of institutionalized sexual discrimination. Table 8.1 shows a comparison of indigenous and non-indigenous Canadian women.

Table 8.1
Comparison of Indigenous and Non-Indigenous Women on Selected Demographic Variables (1989)

Variable	Indigenous Per cent	Non-Indigenous Per cent
Unemployment rate	21	11
Income < $3,000	9	7
Education < Grade 9	13	9
Married	27	30

Source: Statistics Canada, Aboriginal Output Program, 1989

With the exception of the unemployment rate, there are no substantial differences between the groups. However, indigenous women are less likely than non-indigenous women to be married, to attain a basic secondary education and to be free of abject poverty.

Before Euro-Christian contact, many indigenous groups were matrilineal and matrifocal. Some were matriarchal societies where women held powerful

positions as decision makers. Their roles as the carriers of life and primary educators of their children made them crucial to their group's cultural survival. The *Act to Amend the Indian Act* (1985) corrected the long-standing paternalistic definition of indigenous people. Since the majority of adults reinstated as status Indians under the amendment are women, women are increasingly being singled out and isolated as competitors for resources allocated according to "Indian" status. They are also being denied their share of resources by community councils through various loopholes in residency bylaws. The social degradation that women suffer in their own communities is the result of decades of patriarchal imposition, as well as physical and psychological assaults by spouses or boyfriends. In the past, such behavior was never ritualized and was, instead, looked upon scornfully, to the point that people were once banished for it.

Eight in 10 Indian women reported being abused by their partners, versus the average one in 10 reported by all Canadian women (ONWA, 1989). It is claimed that the lives of virtually all Indian females in Ontario are affected in some way by family violence

> *[e]ither as a child witnessing spousal assault, as a child victim herself, as an adult victim of a husband or boyfriend's violence, or as a grandmother who witnesses the physical and emotional scars of her daughter's or granddaughter's beatings ... .*
>
> *(ONWA, 1989:3)*

In the ONWA report *Breaking Free*, 80 per cent of a survey sample indicated that they had personally experienced family violence, with 44 per cent revealing that alcohol was often involved, and another 37 per cent saying alcohol was usually involved.

Substance Abuse in the Indigenous Community

Generally, indigenous substance abuse is inferred from social indicators analysis, with rates of incarceration, violent death, alcohol-related diagnoses/discharges, treatment participation and alcohol sales being used as indicators. In the most recent national survey of "Indian" conditions, it is reported that 17 per cent of *all* Canadian alcohol-related hospitalizations were accounted for by Indians. Admissions to alcohol and drug treatment centres were 13 times the national rate, and 50 per cent to 60 per cent of all indigenous illnesses were alcohol-related (DINA, 1981). By comparison, the IHS (Indian Health Services, U.S.) discharge rates for non-dependent abuse of alcohol and for alcoholic liver disease are both three times as great as the U.S. national rates (5.8 vs. 1.7 per 100,000, respectively). The alcohol dependency syndrome rate is nearly twice the U.S. national rate (35.8 vs. 19.7 per 100,000), and the IHS discharge rate for alcoholic psychosis is four times as great as the U.S. national discharge rate (11.8 vs. 2.9 per 100,000) (Young, 1988:129).

Traditional formulae that extrapolate alcoholism prevalence from liver cirrhosis rates are not appropriate for the indigenous population, because the indigenous lifespan is too short. Similarly, the marginalization of indigenous groups has made it difficult to include their statistics in Canadian databases. The most indicative records, because of their equalization value, are statistics on violent deaths, a large proportion of which are related to substance abuse (Jarvis & Boldt, 1982; Kraus & Buffler, 1977; Maris, 1985; Westermeyer, Walker & Benton, 1981). Violent death includes suicide, homicide, poisoning/overdose, accidents (motor vehicle, air and water transport, firearms), drownings, and death due to fire, falls, suffocation, overexposure and negligence.

Death by violent means accounted for a large proportion of deaths in Registered Indians in Saskatchewan (40 per cent) (Fiddler, 1985) and British Columbia (Jilek, 1982). Deaths from violence were 3.5 times more likely in Registered Indians than in the total Saskatchewan population, and suicide deaths were 4.3 times more likely. Suicide deaths were also more likely in female Indians than for non-indigenous Saskatchewan women: the female to male ratio for suicide was 1:2 for Indians but only 1:4 for non-Indians in Saskatchewan (Fiddler, 1985). Suicide was particularly high in young Indian women (15 to 29 years of age) who experienced 14.5 times more suicide than non-Indian Saskatchewan women. Alcohol and drug overdose was the most common form of suicide among Saskatchewan Indian females (accounting for 34 per cent of all suicides in this group). Fiddler (1985) explains that the discrepancy between the sexes in suicide rates may be attributed to sex roles. Females can still participate in their traditional role as mother and caregiver, whereas traditional economic roles are not available to males.

In Saskatchewan, accidental and violent death was also more likely among Indians. Indian females are 3.5 times more likely to die this way than their non-indigenous counterparts, especially in the younger age groups (under 25 years of age). Northern groups fared far worse than those in the less isolated zones.

The Medical Services Branch (MSB) of HWC, responsible for Indian and Inuit Health Services, reported that the leading causes of death, in descending order, were injury and poisoning (including suicides), circulatory diseases, neoplasms (cancer), and respiratory diseases – with the exception of figures for the Atlantic, Quebec and Ontario regions, where deaths due to circulatory system diseases were more prevalent than deaths due to injury and poisoning. Comparatively, age-specific suicide rates are three to seven times the Canadian rates for those in the 15- to 34-year-old age group, with the greatest difference found for those in the 15- to 19-year-old age group, followed closely by those found for the 20- to 24-year-old age group (HWC, 1986). Sex-specific data indicated that males accounted for a greater percentage of total deaths in each category. "The largest gap between male and female deaths is found in the injury and poisoning [category] ... " (HWC, 1986:B-104). Because violent death (suicide, injury and poisoning) is the leading cause of adult mortality and has been significantly correlated with substance abuse, it is clear that a substance-abusing lifestyle is the most significant health problem among indigenous groups serviced by Indian and Inuit Health Services. In addition, a U.S. study (Malin, Munch & Archer, 1978) found that almost half of all cirrhosis deaths among American Indians were women, and the mortality rate for American Indian women aged 15 to 34 years was 37 times the rate for American women in general.

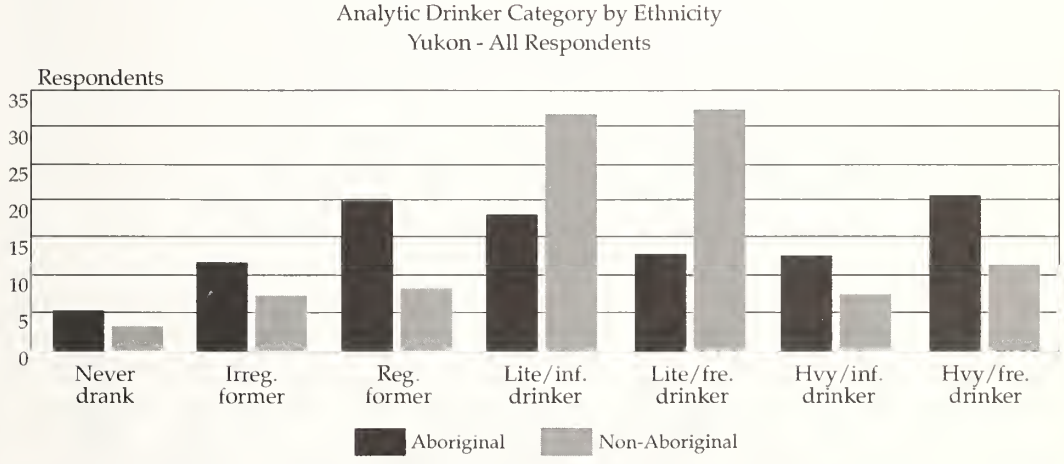
The Northwest Territories Health Promotion Survey (HWC, 1989) provides valuable information on women of two Aboriginal groups, the Inuit and the Dene, who have been grouped together to form an indigenous female group for comparison with indigenous males and all Canadian females. When asked: "What is the most significant thing you should do to improve your health?" only indigenous respondents answered "reduce drinking" (Indigenous Females [IF] = one per cent, Indigenous Males [IM] = five per cent). Indigenous women were least likely to say they were very happy (IF = 16 per cent vs. IM = 31 per cent, and Canadian Females [CF] = 43 per cent). When asked if they currently

smoke cigarettes, indigenous women and men reported substantially higher positive answers than all Canadian women (IF = 72 per cent, IM = 71 per cent, CF = 38 per cent). Both indigenous groups were also more likely to report smoking regularly (IF = 57 per cent, IM = 59 per cent, CF = 33 per cent).

Responses to questions on alcohol consumption revealed that all Canadian women were more likely to have ever taken an alcoholic beverage (96 per cent) than either indigenous men (85 per cent) or indigenous women (81 per cent), and more had consumed alcohol in the past year (CF = 90 per cent, IM = 70 per cent, IF = 62 per cent). This relative ranking is consistent with responses to questions about the frequency of drinking in the previous year and previous seven days. However, the relative ranking changes when respondents are questioned about heavy consumption (four or more times per week). Here, it is evident that indigenous men outrank indigenous women, who in turn outrank all Canadian women, which indicates a clearly greater polarization in drinking patterns among this northern group. Indigenous men were most likely to have used cannabis (30 per cent) in the past 12 months, with indigenous women ranking second (16 per cent) and Canadian women third (10 per cent). Indigenous women were more similar to their male counterparts than to Canadian women with respect to substance use and to social reinforcement of opportunities for substance use.

In the recent Yukon Alcohol and Drug Survey (Yukon Government, 1991), roughly 24 per cent of respondents were indigenous. Figure 8.1 breaks down these data by ethnicity and drinker category.

Figure 8.1
Drinker Category by Ethnicity (Yukon)



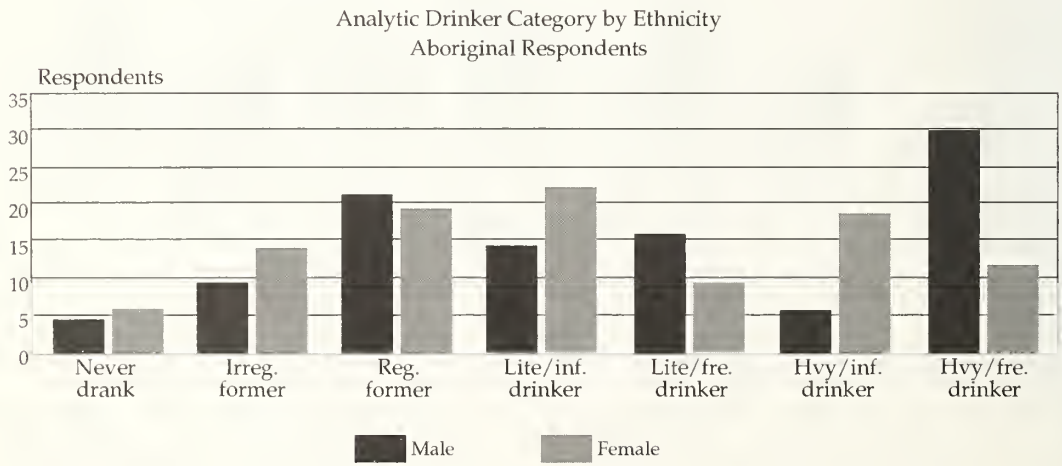
Note: FRE = frequent, INF = infrequent, IRREG = irregular, HVY = heavy

Consistent with the Northwest Territories Health Promotion Survey data, a greater polarization in drinking patterns occurs among indigenous groups than among non-indigenous groups, which is maintained when groups are broken down by sex. When drinker categories are broken down by ethnicity and age, it is clear that the greater polarization in drinking patterns is accounted for by groups of populations over 20 years of age. Non-indigenous adolescents were slightly more polarized in drinking patterns than their indigenous counterparts in the Yukon sample. Indigenous women were more likely to have irregular/infrequent drinking patterns than their male counterparts, and men were almost three times more likely than women to declare themselves heavy frequent drinkers. The comparison between the sexes is depicted in Figure 8.2.

Canadian Indigenous Addictions Organizations

In 1975, the National Native Alcohol Abuse Program (NNAAP) was established. It became the National Native Alcohol and Drug Abuse Program (NNADAP) in 1982. More recently, NNADAP has been brought under the umbrella of Addictions and Community Funded Programs (ACFP) of the Medical Services Branch, Health and Welfare Canada. NNADAP's mandate is to provide funding for treatment, prevention, training, research, and development to combat substance abuse among Registered Indian people residing on reserves. In the early 1980s, NNADAP sponsored regional needs assessments, which Whitehead (Whitehead Research Consultants Ltd., 1985) reviewed to produce a national picture of indigenous addictions. He criticized the regional needs assessments for a variety of methodological errors. However, where

Figure 8.2
Drinker Category by Sex (Yukon Aboriginal Respondents)



Note: FRE = frequent, INF = infrequent, IRREG = irregular, HVY = heavy

the prevalence and nature of abuse have been validly and reliably obtained, important information resulted. Unfortunately, such sound information was available only for the Atlantic region, Quebec, Saskatchewan and the Northwest Territories.

Among indigenous people in New Brunswick,

> *... alcohol abusers are over-represented in the 25- to 44-year old age group, with 50 per cent of the population of abusers falling into this age group compared to about one-quarter of the on-reserve population of New Brunswick. Men were more likely than women to be identified as alcohol and/or drug abusers (72 per cent vs. 28 per cent). Women were more likely on the other hand to abuse drugs alone (67 per cent vs. 55 per cent). (Whitehead Research Consultants Ltd., 1985)*

Addictions counsellors in New Brunswick suspected that women were abusing prescription mood-altering drugs. Although only one-third of known abusers were married, more than half lived with dependent children. In reviewing the off-reserve detoxification and rehabilitation facilities in New Brunswick, it became evident that although indigenous groups account for less than one per cent of the total population, they represented over six per cent of those admitted to these facilities.

Of the 27 communities that participated in the Quebec needs assessment, 11 rated the extent of drug abuse above 2.5 on a five-point scale, when ranking the seriousness of the problem. (Lower scores indicate the existence of abuse in some groups; higher scores indicate the existence of widespread, chronic abuse leading to social chaos.) Five communities rated the extent of drug abuse above 3.0. When ranking the seriousness of alcohol abuse on the same five-point scale, 20 communities gave scores above 2.5, 16 gave scores above 3.0, and three gave scores above 4.0. When questioned about which substances caused the most damage among indigenous women in Quebec, 19 of the 27 communities stated alcoholic beverages (mainly beer and liquor), while seven communities named cannabis as the most damaging substance. Key informants in the Quebec assessment believed that substance availability/acceptability, economic conditions, social isolation and cultural changes all contributed to substance abuse in the indigenous community.

In a survey conducted by WMC Research Associates (1984) with a Saskatchewan indigenous sample, responses revealed that males were more likely to consume alcohol (M = 87 per cent, F = 80 per cent) and almost twice as likely to abuse it (M = 48 per cent, F = 26 per cent) than were females. Drug use patterns were similar, with 50 per cent of the females and 62 per cent of the males reporting drug use. Of those females, 20 per cent reported frequent drug use, while 32 per cent of the males reported using drugs regularly. Of the sample, 38 per cent engaged in abusive types of drinking, and alcohol abuse represented a more serious problem than drug abuse. From the Saskatchewan NNADAP counsellors' perspective, lost cultural elements and economic conditions have precipitated abuse problems. The Saskatchewan provincial alcoholism commission serviced 8,000 clients during the fiscal period 1982–83, of which seven per cent were Treaty Indians.

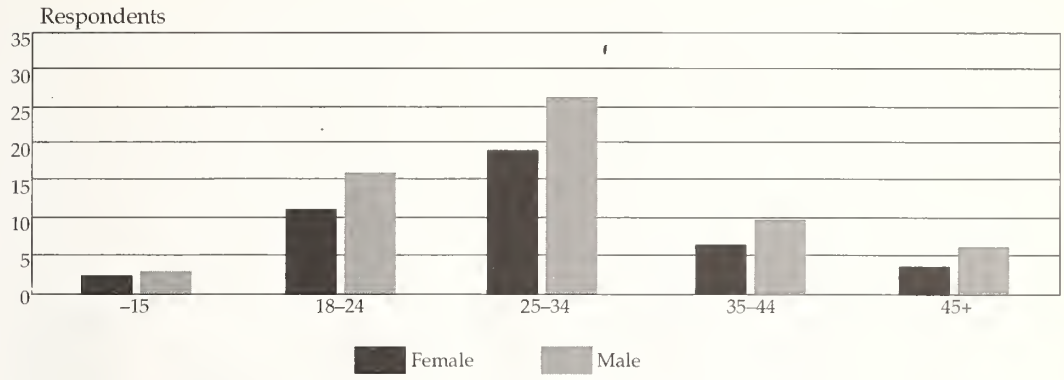
In the Northwest Territories, "alcohol abuse ranked as the most serious problem facing people of the Northwest Territories" (Whitehead Research Consultants, 1985:85). Between 1982 and 1984, 220 clients received rehabilitation services at Delta House in the Inuvik region (it is not reported, however, what proportion of these clients was indigenous). In the Fort Smith region, Northern Addiction Services indicated that 83 per cent of its client caseload was indigenous (no base figure, however, is reported). Pauktuutit Inuit Women's Association (1990) reveals that substance abuse, inadequate housing or housing shortages are viewed as the most serious health problems facing the Inuit community. Clearly, these data are non-comparable. However, they suggest that alcohol is the substance of choice among abusers, and that men are more likely to abuse than women. In addition, there is noted social acceptance of excessive alcohol use, and often peer pressure encourages it.

Indigenous Treatment Centre Activity

Indigenous treatment centres are residential facilities with intensive, non-medical, culturally sensitive programs usually ranging in duration from four to six weeks and primarily based on a psychotherapeutic model. Detoxification and medical examinations are entrance requirements and often, court-ordered treatment cases are not accepted. There are 51 NNADAP-funded treatment centres across Canada, whose bed allocations have been determined by a Registered Indian population formula.

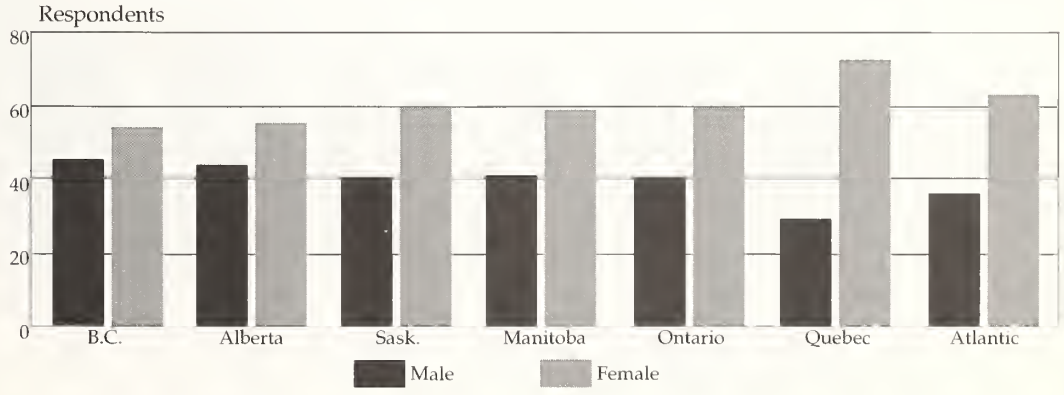
The Treatment Activity Reporting System (TARS) yields the most recent systematic data on the institutionalized, chemically dependent indigenous female. TARS provides information on admission and occupancy rates, abused substances, cross-addiction patterns, operational costs, and age- and sex-specific differences. In descending order, national TARS (NNADAP, 1991) data reveal that alcohol, narcotics and hallucinogens are the most widely abused substances, with alcohol being about four times more likely to be the substance of choice among abusers. When the data are broken down by region, it becomes clear that hallucinogens consistently rank second in the Pacific region and, during one quarter, in the Atlantic and Quebec regions. However, it should be stated that there exists some confusion regarding the classification of cannabis. Although cannabis is not a narcotic, it is pharmacologically classified as a hallucinogen (Cox, Jacobs, LeBlanc, Marshman & Fehr, 1987). It is classified as a narcotic in the statistics cited here. Thus, the category "narcotics" here includes predominantly cannabis. The most popular cross-addiction patterns involved alcohol and narcotics, alcohol and hallucinogens, alcohol and prescription drugs, followed by narcotics and hallucinogens, and narcotics and prescription drugs. Based on the national client profile, a total of 1,460 clients received treatment, roughly 40 per cent of whom were female. The distribution of females and males by age in treatment is depicted in Figure 8.3.

Figure 8.3
Percentage Distribution of Treatment Participation by Age and Sex, April–September 1991



The bulk of treatment participants are in the 25- to 34-year-old age group, with men greatly outnumbering women. When the data are broken down by region (see Figure 8.4) it becomes obvious that as we move from the Atlantic provinces to British Columbia, the discrepancy between the sexes in treatment participation narrows.

Figure 8.4
Percentage Sex Distribution of Treatment Participation by Region, April–September 1991



Figures 8.5 and 8.6 depict average treatment participation by age and region for both sexes for the period from April to September, 1991.

Figure 8.5
Percentage Age Distribution of Treatment Participation by Region, 1991 (Females)

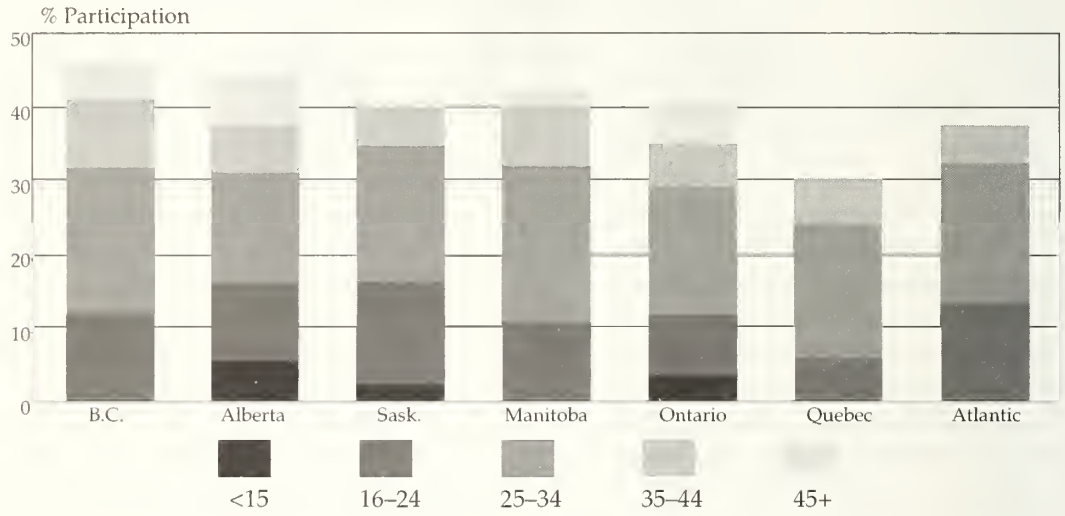
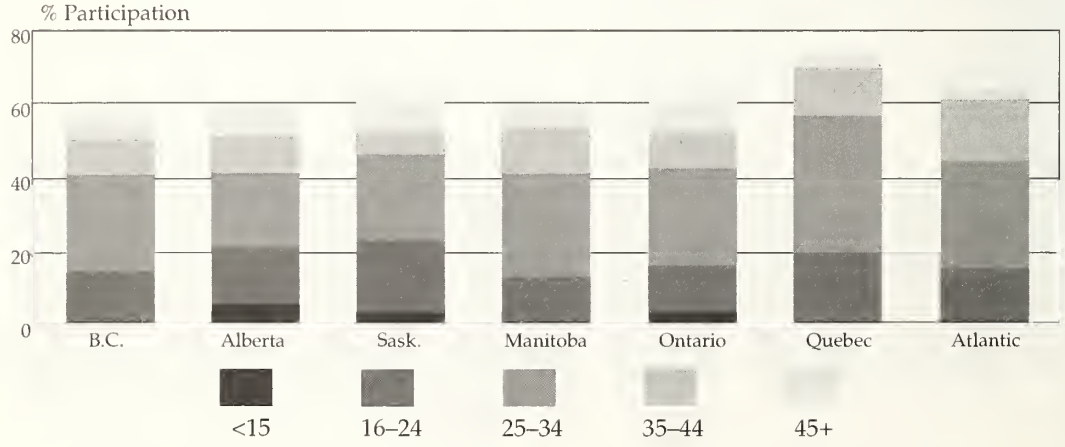


Figure 8.6
Percentage Age Distribution of Treatment Participation by Region, 1991 (Males)



It could not be discerned from TARS which prescription drugs were being abused, and by whom, or what the impact of gender was on relapse rates, cross-addictions and substances abused. Across regions it appears that the greatest participation rate is in the 25- to 34-year-old age group, with Alberta having the greatest number of child participants, and males consistently outnumbering females in all categories across regions. Interestingly, these are stable patterns in the TARS data (NNADAP, 1989).

Because none of the treatment centres offer child care on site or support it financially, indigenous women must choose between fulfilling their responsibilities as child rearers and obtaining chemical dependency treatment. Further, indigenous women often have to travel from their home communities to seek treatment. Their child-care options include making private arrangements, for which they are financially responsible, or voluntarily placing their offspring with a child welfare agency. In the latter case, the women may or may not be in a position to select with whom their children stay. An indigenous woman must act as "baby-maker, child-rearer, and husband-nurturer" (NWAC, 1981:12). She is stigmatized in a manner that is real and formidable, and is perceived as selfish if, instead of fulfilling these roles, she seeks treatment. Burns (1983) appropriately points out that fundamental physiological considerations (including menstruation, menopause, pregnancy, miscarriage and abortion) must also be considerations in indigenous addiction treatment centres, as in all addictions treatment for women, because of the impact of drugs on physiology, and vice versa.

Substance Abuse and Indigenous Women

Before September, 1989, the National Native Advisory Council on Alcohol and Drugs was the governing body of the NNADAP. In its annual reports and newsletters, there was clearly a special focus placed on suicide, urban groups, the Inuit, sexual abuse, unemployment, Fetal Alcohol Syndrome (FAS), abuse of prescription drugs, and spousal abuse. It can be inferred that the special attention to FAS, sexual abuse, abuse of prescription drugs, and spousal abuse may have reflected a particular concern with gender-associated issues. NNADAP has funded major self-help efforts for indigenous women, including the publication of *Your Child! Our Future!: Fetal Alcohol Syndrome Education Package and Resource Kit*, as well as the Northern Addiction Services adaptation of *It's Just Your Nerves, Eh?* Other sources of gender- and indigenous-specific addiction programs certainly do exist wherever self-help groups have evolved, but they are largely unknown to Western research, which relies heavily on the written word – a grossly inefficient form of communication in the indigenous community. In discussions with indigenous organizations, the unwillingness to isolate substance abuse among women was clear. Rather, the organizations wanted it to be known that, regardless of their own consumption patterns, virtually all indigenous women are affected by substance-abusing lifestyles.

In the *Your Child! Our Future!* package, McTimoney, Savoy and van Gaal (1989) noted that FAS incidence rates are indeed higher than average among indigenous Canadians. Conservative estimates of FAS/Fetal Alcohol Effect (FAE) incidences in samples of the total population yielded one to three live births per 1,000 (Rosett, 1980). In

McTimoney et al. (1989), American studies cite an Indian FAS incidence rate ranging from 1.4 to 9.8 per 1,000. In other American Indian samples, Malin, Munch and Archer (1978) discovered a higher prevalence of FAS/FAE. Asante and Nelms-Matzke (1985) discovered an FAS/FAE rate of 25 per 1,000 children (0 to 16 years) among indigenous northwestern British Columbia populations (Métis and Indian), and 46 per 1,000 among Yukon indigenous groups, as compared with 0.4 per 1,000 for the total population in both regions.

The Native Women's Association of Canada's (NWAC) Report for the NNAAP (1981) focused on alcohol abuse and "verified the existing common knowledge to Indian women that theirs is a bleak outlook of unmet needs" (p. 10). From NWAC's work, it appears that abuse occurs mostly among single women who have no relief from poverty and isolation (NWAC, 1981). Consistent with the general literature on addictions and self-image, indigenous women cited low self-esteem as an important factor in chemical dependency, as well as lack of control over their situation and poor coping skills. The NWAC report heavily emphasized a familial focus for treatment, and parenting- and coping-skills courses for prevention.

In the urban context, alcohol seemed to be the drug of preference for indigenous women where severe levels of abuse among all age and target groups existed (Lafontaine, 1985 for NAFC). Seventy-five per cent of responding friendship centres reported that pregnant women in their communities use and abuse substances, with levels varying from light use to life-threatening abuse, and with the most commonly abused substances being alcohol, cannabis and prescription drugs. It is suspected that the listing represents a hierarchical order, as there is much evidence to indicate that alcohol is the substance of choice among indigenous groups (NNADAP, 1989, 1991; Whitehead Research Consultants, 1985). Reported reasons for abuse suggested that the abuse was either socially motivated or related to coping. Consequences of abuse included marriage breakup, depression, FAS, child apprehension by social welfare agencies at birth, death, drug withdrawal, disease, accidents and criminal behavior. Single women were also noted to abuse alcohol, illicit and prescription drugs for social and stress-related reasons. The perceived negative effects of their substance abuse included poor reputation, child care and nutrition; suicide; sexually transmitted disease; accidents; death; unwanted pregnancy; and employment and school problems.

Discussion

Health data at the community level are collected primarily by the federal government (i.e., MSB, HWC), whose collection methods vary considerably among regions, and from provincial systems, making national normative data unavailable. Where survey research is available, the construct validity (conceptualization) and reliability of the instruments or research methods used are rarely discussed. In addition, because some indigenous communities have been grossly overstudied, data in these communities are complicated by community apathy or majority non-participation. "Research" has usually been conducted with an externally derived agenda based on reductionist principles which try to find overly simple explanations, with little or no tangible community benefits associated. In indigenous science, significantly greater value is placed on holism and the subjective; therefore, cultural barriers complicate communications, data collection and interpretation.

The more narrowly defined research population of indigenous people lacks a sufficient addictions database with which to assess sample representativeness. General Canadian groups, therefore, have served as the population of comparison, despite the non-comparability of the two groups on several demographic variables. Data from convenience samples of Indian populations are not generalizable and may not be representative of the experiences of urban Métis and other non-reserve communities. Scattered groups may be too heterogeneous in community structure and, even within communities, many people recognized by the federal government as "Indian" are of various racial and ethnic origins. In addition, urban indigenous populations are either not identified or do not participate in Canadian polls, such as the recent National Alcohol and Drug Survey (NADS). To date, only NNADAP's Treatment Activity Reporting System is comparable across regions and is the best, most systematic collection of data on indigenous substance abuse.

Recommendations for Future Research

Clearly, there is a socially devastating addictions problem, and it could easily be argued that no further data are required to attest to the human suffering. From this position, it would be most practical to support community initiative and creativity to arrest the problem. Following rigorous evaluation procedures, initial programs could be modified to make them viable in other communities. In order of priority, it would be useful to know:

1. Which programs or models seem most successful for indigenous women?

2. What are the program needs and preferences of addicted indigenous women, taking into account such factors as age, residence and socioeconomic status?

3. How can the attitudinal and institutional barriers to indigenous women's rehabilitation be eliminated?

4. What roles do culture, economics, personality traits, self-image, locus of control, community characteristics and sexism play in indigenous women's rehabilitation or their abstinence?

5. Are there any indigenous- and gender-specific substance abuse programs within provincial health care systems?

6. What are indigenous women's substance-specific ages at onset of use, cross-addiction patterns, consequences and nature of abuse?

For national program and policy development purposes, information could be gathered from the evaluation of these initiatives and could include direct, valid, reliable, quantitative assessment of consumption patterns for the most commonly used substances (i.e., alcohol, tobacco, cannabis) broken down by age, sex, band affiliation, geographic location and socioeconomic status. In addition, substance abuse related diagnoses and hospital discharge statistics could be collected in evaluation studies.

The research must bear maximum relevance to the situation of indigenous women. This can only be achieved in partnership with them, or if they control the research, focusing and developing the research endeavor to suit their circumstances. Some national program data needs should be satisfied by the Post-Censual Aboriginal Peoples Survey.

Although the adult survey (of respondents 15 years of age and over) will contain only questions on cigarette smoking and alcohol consumption, and although it will not capture age at onset of use, it will be the first national survey of direct addictions data for this population. Unfortunately, illicit and prescription drug usage have been omitted from this survey, but have been strongly recommended for future endeavors.

Conclusion

Indigenous female children (i.e., under 15) have entered alcohol and drug treatment centres, and proportionately more females participated in treatment in the western provinces, with the bulk being 25 to 34 years of age. Females accounted for about one-third of those over age 25 receiving treatment. Consistently, the data indicate that indigenous women were less likely to use and abuse alcohol than their male counterparts, with the greatest discrepancy in this regard existing in the Atlantic region. Alcohol is clearly the mind-altering substance of choice among indigenous males and females with the exception of those living in the Atlantic region, where women may be more likely to abuse drugs than alcohol.

Indigenous women, especially those 15 to 35 years of age, are at greater risk for abuse-related mortality when compared with their counterparts in the general population, and their risk for abuse-related death is substantially lower than that for their male counterparts. It appears that indigenous women residing in Quebec, Ontario and the Atlantic region may not abuse substances with the same severity as indigenous women in other regions, as evidenced by mortality and treatment participation patterns. However, lower rates of treatment in these regions may be the result of lesser availability of treatment services. It must also be noted that the factors of acculturation, socioeconomic status and social integration in eastern groups have not been taken into account. The northern data suggest that there is a greater polarization in alcohol consumption patterns, and that indigenous women were found to be more external in locus of control orientation than women in mainstream groups, but more internal than their male counterparts. The presence of social support or peer proscriptive norms (which discourage use) seems consistently related to use across sex and age groups. Some national attention has focused upon the program needs of indigenous women; however, the community-based success stories are untold. Essentially, our knowledge of how to empower and heal the addicted indigenous woman is pathetically limited, but could be strengthened by support for her creative and too often under-resourced healing efforts.

Notes

1. Indigenous persons comprise Indians, Inuit and Métis. The number of Registered Indians – recognized by the Department of Indian Affairs – is much smaller.

2. Only Indians and Inuit are recognized as a federal responsibility, although the Métis are constitutionally recognized as Aboriginal people.

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CHAPTER 9

Licit Drug Use and Dependence among Canadian Women

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Lucia Farinon

Women have traditionally used more licit drugs – particularly prescription psychoactive drugs – than men have. This chapter examines both prescription and over-the-counter (OTC) drug use.

Prescription Drug Use

In the past two decades, researchers have shown a major interest in gender differences in the use of psychotropic drugs – that is, prescription psychotropic drugs with the potential to encourage dependency. These include tranquillizers such as Valium; opiates such as codeine, Demerol and morphine; and sleeping pills. In 1976, Ruth Cooperstock concluded that:

> *[c]ritical to an examination of sex differences in drug use today is an understanding of the expansion of the medical model to encompass more aspects of our lives. This, along with the development of psychotropic agents, has had a profound effect on the medical profession, not the least of which has been the sanctioning, within a medical model, of a variety of culture-bound views of women, as well as the provision of the tools with which to "treat" the "problems" seen.*
>
> *(Cooperstock, 1976:763)*

This view is supported by Penfold and Walker (1983), who argue that clinician stereotyping and expectation played a major role in shaping women's "illness behavior" and in determining physicians' prescribing patterns. They suggest that, within the medical framework, women's distress is viewed as a

psychiatric disorder alone and that psychotropic drugs are seen as the quickest and best treatment of choice.

The concern arises from the potential for use to become abuse, and of the user to develop a tolerance to mood-altering drugs. The ability of a drug to reinforce drug-taking behavior is an essential determinant of its potential for encouraging abuse (Woods, Katz & Winger, 1987). Woods et al. (1987:254) defined psychological dependency as "the reinforcing potential of drugs, i.e., their potential to increase or maintain the frequency of the behaviors of drug seeking or drug taking." The severity of withdrawal is related to dose and duration of use. Withdrawal effects can be relieved by administering the drug or another in the same class.

Prevalence Studies

A review of the literature clearly indicates that the use of psychotropic drugs is greater among women than among men. Cooperstock and Parnell (1982) reviewed studies of licit psychotropic drugs conducted in the United States, Australia, Canada and Europe. They concluded that, despite methodological problems in many of the studies, use was usually highest among women, the elderly, and those in poor physical health.

Many large epidemiological studies support the view that women outnumber men as psychotropic drug users (Isacson & Haglund, 1988; Catalan, Gath, Bond, Edmonds, Martin & Ennis, 1988; Clare, 1981; Mellinger, Balter & Uhlenhuth, 1984). Rosser (1984) reported on a large Canadian study conducted at the Ottawa Civic Hospital's Family Medicine Centre. Of 12,716 patients seen during 1982, 410 (three per cent) received 742 prescriptions for benzodiazepines (a type of sedative). Of these, 71 per cent were prescribed for women and 29 per cent were prescribed for men.

The Elderly

Jacyk, Tabisz, Badger and Fuchs (1991) studied patients over age 65 seen at hospital emergency departments. They reported that 30 per cent of the patients screened required some form of intervention for chemical dependency. Women represented 73 per cent and males 26 per cent of the positive benzodiazepine users. Among the positive opiate (painkiller) users, women represented 91 per cent and men nine per cent.

There has been increasing interest in the misuse of medication among the elderly. Studies of the elderly in Saskatchewan highlight the potential problem (Skoll, August & Johnson, 1979). Grymonpre, Sitar, Montgomery, Mitenko and Aoki (1991) examined Manitoba's Pharmacare plan for the years 1975, 1978, 1981 and 1984. Their sample consisted of claimants aged 50 and older who were prescribed six or more medications. The gender distribution of older claimants approximated that of the province's over-65 population (55 per cent female), and the gender difference in number of drugs prescribed was not statistically significant. Benzodiazepines and codeine were the most commonly prescribed psychotherapeutic drug categories for the elderly claimants. Over the decade, more women than men, aged 50 and older, received prescriptions for all categories of psychotropic agents, including barbiturates and antidepressants. The authors speculated that elderly heavy drug users who were prescribed benzodiazepines were at increased risk for adverse drug reactions.

Data from the 1979 Canada Health Survey confirmed the trends found in provincial drug plan studies (Statistics Canada, 1981). A strong association was found between age, gender and tranquillizer use (Weiss, 1990). Overall, six per cent of female and three per cent of male respondents had taken tranquillizers in the two weeks preceding the survey. While only five per cent of women and two per cent of men in the 25- to 44-year-old age group consumed tranquillizers, the percentages rose to 20 per cent and 10 per cent respectively in the over-60 age group (Statistics Canada, 1981).

In an earlier study, Grymonpre, Mitenko, Sitar, Aoki and Montgomery (1988) examined drug-related admissions to the Health Sciences Centre in Winnipeg for those aged 50 and older. Of 863 eligible admissions, 19 per cent (162) exhibited at least one drug-related adverse patient event (DRAPE) which was the main or contributing cause for hospitalization. Females had significantly more adverse drug reactions (although gender was not a predictor for overall DRAPE risk), and benzodiazepines were identified as high-risk drugs.

In Lexchin's (1989) review article of Canadian studies, the author found that the elderly received proportionately more prescriptions than any other age group in Canada. The most common groups of drugs prescribed were the psychotropic and cardiovascular drugs, principally digoxin and diuretics. Elderly women received the bulk of prescriptions for psychotropic agents.

In cross-national surveys in Canada and the United States, 12 per cent of adults reported using a prescribed anxiolytic or sedative medication in the past year. This rate rose to 15 per cent among the elderly (Woods, Katz & Winger, 1987). The Canada Health Survey (Statistics Canada, 1981) indicated that five per cent of Canadian adults reported using tranquillizers or sleeping pills in the past two days, with more than three times this rate (16 per cent) among the elderly.

Over-the-Counter Drug Use

Women use more over-the-counter (OTC) drugs than do men. Patterns of prescription drug abuse and dependence appear to be representative of OTC drug use and misuse. Women are twice as likely as men to be dependent on prescribed psychoactive medications (Ogur, 1986). A survey of OTC drug use among adults in Illinois showed that women use and misuse tranquillizing medications more often than men, while men use OTC drugs with stimulant properties more often than women (Bell, 1984). Another study found that the intake of both curative and preventive drugs is considerably higher among women than among men (Verbrugge, 1982).

A 1983 Winnipeg survey of self-care behavior gives some insight into the extent of OTC medication use. Seventy to 90 per cent of all illnesses were self-treated without being brought to a physician's attention. Ninety-five per cent of respondents in this survey reported current use of OTC medication in the home, with an average of three remedies being currently used. In the previous two-week period, 63 per cent of those surveyed had consumed at least one OTC product. More significantly, 94 per cent of these people found the self-treatment to be effective (Segall, 1990).

Many factors have been implicated in the causes of increased prescription and OTC drug use and misuse among

women. Some of these factors include psychosocial problems, a history of psychiatric illness, unstable family, physical abuse, psychological distress, low self-esteem, drug use and misuse at an early age, sensation seeking and poor relationship with parents (Bry, 1983). One study found some common denominators among women who abused OTC drugs. They had less education, a higher unemployment rate, more chronic physical and mental conditions, and were more likely to feel helpless than women without a history of OTC drug abuse (Verbrugge, 1982).

The elderly are particularly at risk for adverse drug reactions from OTC medications, as two-thirds of people over age 60 take at least one OTC medication per day (Abrams & Alexopoulos, 1988). The increased quantity of prescribed medications among the elderly puts them at greater risk for drug interactions with OTC preparations as well. A survey of analgesic use by the elderly in Iowa found that 14 per cent of women and 10 per cent of men used more than one pain-relieving product in the preceding two-week period (Chrischilles, Lemke, Wallace & Drube, 1990).

The abuse of non-narcotic analgesics, particularly acetaminophen, is an increasing problem that affects women five to six times more often than men (Gallagher, Weisshein & Weisshein, 1988). The extent of dimenhydrinate abuse among women is also becoming more apparent, mainly because of the drug's anorectic and emetic properties (its potential to suppress the appetite and induce vomiting) when taken at high doses (Young, Boyd & Kreeft, 1988). Phenylpropanolamine (PPA) is available in more than 70 OTC products in the United States and Canada. Many problems related to the misuse and abuse of PPA are now evident, particularly among women taking it for appetite suppression. Serious complications stemming from PPA misuse include hypertension, tachyarrhythmias and seizures (Bravo, 1988).

The consequences of OTC drug misuse and abuse are many and varied, but those specific to women include reproductive disorders, adverse effects on the fetus and problems with parenting (Bry, 1983). Bry reports that prevention of OTC drug abuse in women involves both primary and secondary interventions. Primary approaches are used to educate adolescent women before OTC drug use becomes a problem. Secondary interventions, aimed at women who have already developed abusive patterns of OTC drug use, attempt to provide the education and support necessary for rehabilitation.

Analytical Approach

Data from the National Alcohol and Other Drugs Survey (NADS) were analyzed to determine the extent to which Canadian patterns of psychotropic drug use correspond to trends apparent in the literature. In particular, the authors wished to confirm that although psychotropic drug use among adults generally is low, it becomes a significant issue in specific age and sex groups. In addition, in order to assess OTC medication use among women, the authors considered six of the drug categories from the NADS (ASA or similar pain relievers; diet pills or stimulants; codeine/Demerol/morphine; allergy medicine; cough and cold remedies; and sleeping pills) using the variables of age, sex, marital status, education and income.

Results: Findings from the National Alcohol and Other Drugs Survey

Psychotropic Drug Use

In the NADS survey, respondents were asked about their use of prescription psychotropic drugs in the past 30 days. The following discussion focuses on tranquillizers such as Valium, opiate painkillers (codeine, Demerol or morphine) and sleeping pills.

Overall, three per cent of respondents had used a tranquillizer, such as Valium (four per cent female, two per cent male; sex ratio F:M = 2.3:1). Five per cent of respondents had taken codeine, Demerol or morphine (six per cent female, four per cent male; sex ratio F:M = 1.3:1) and four per cent had taken sleeping pills (five per cent female, three per cent male; sex ratio F:M = 1.8:1).

Ten per cent of respondents reported consuming at least one or more of tranquillizers, opiates or sleeping pills (12 per cent female, eight per cent male), and 1.5 per cent used two or more of these drugs (two per cent female, one per cent male).

Drug Use by Age and Gender

Analysis of NADS data showed that, regardless of respondents' sex, tranquillizer use increased with age. The highest rate, eight per cent, was found among women aged 45 to 64, and the lowest rate, less than one per cent, was reported by men aged 15 to 24. Tranquillizer use was significantly higher among women than among men in all age categories, except the youngest (15 to 24 years), where no significant difference between the sexes occurred (Table 9.1).

Significant differences between the sexes in their use of opiates, such as codeine, Demerol or morphine, were found among the 25- to 44-year-old and the 45- to 64-year-old groups, with women reporting higher rates. Use among men tended to decrease with age, whereas it remained more stable for women (Table 9.2).

Use of sleeping pills increased significantly with age among both women and men. Women's use was significantly greater than men's in the 15 to 24 and 45 to 64 age groups. The highest consumption of sleeping pills was reported by those aged 65 and older, with 12 per cent of women and 10 per cent of men using them (Table 9.3).

Figure 9.1

Gender Differences in Prescription Psychoactive Drug Use in the Past Month by Marital Status, Sex and Sex Ratio

Marital Status	Tranquillizers F %	M %	F:M Ratio	Opiates F %	M %	F:M Ratio	Sleeping Pills F %	M %	F:M Ratio
Single/ NeVer Married	2.2	1.5	1.5	5.5	4.7	1.2	2.4*	1.0	2.4
Married	3.8	1.9	2.0	5.7*	4.0	1.4	3.6	3.1	1.2
Separated/ Divorced	8.7*	2.7	3.2	8.0	5.9	1.3	6.9*	3.6	1.9
Widowed	8.9*	1.0	8.9**	7.7	2.4	3.2**	13.8	7.3	1.9

* Significant sex differences ($p<0.05$)

** n<5

Figure 9.2
Gender Differences in Prescription Psychoactive Drug Use in Past Month by Education, Sex and Sex Ratio

Education	Tranquillizers F %	M %	F:M Ratio	Opiates F %	M %	F:M Ratio	Sleeping Pills F %	M %	F:M Ratio
< High School	6.4*	2.0	3.2	5.0*	3.1	1.6	6.9*	3.3	2.1
Completed High School	4.0*	2.0	2.0	6.4*	4.5	1.4	4.2	2.9	1.4
Post Secondary/ Non-universtiy	3.7*	0.8	4.6	5.6	4.7	1.2	3.2*	1.8	1.8
University Degree	1.5	2.3	0.6	6.6	6.1	1.1	2.5	1.6	1.6

* Significant sex differences ($p<0.05$)

Figure 9.3
Gender Differences in Prescription Psychoactive Drug Use in Past Month by Income, Sex and Sex Ratio

Income	Tranquillizers F %	M %	F:M Ratio	Opiates F %	M %	F:M Ratio	Sleeping Pills F %	M %	F:M Ratio
< $19,999	5.3*	2.4	2.2	5.1	4.8	1.1	5.5	4.3	1.3
$20,000–$39,999	3.8*	1.5	2.5	7.3	4.6	1.6	3.1*	1.5	2.1
$40,000 +	5.3*	1.7	3.1	7.9	4.9	1.6	6.2*	1.5	4.1

* Significant sex differences ($p<0.05$)

Marital Status and Drug Use

Separated, divorced and widowed women reported a higher intake of opiates, tranquillizers and, particularly, sleeping pills than did married and single women (Table 9.1). Among men, this was the situation only for sleeping pill use. Women's use of sleeping pills was significantly higher than that reported by men in the single and separated/divorced categories.

Regarding the use of opiates (painkillers), the only difference between the sexes was found among married respondents, with rates of six per cent among women and four per cent among men. Women's use of tranquillizers was significantly higher than men's in all marital status categories except "single/never married." Of concern was the use of sleeping pills among 14 per cent of widowed women – the highest reported rate of use among any age or sex group.

Women's use of tranquillizers, sleeping pills and opiates varied according to marital status. The pattern of use of all three drugs was lowest for single women – followed by those who were married or separated/divorced – and highest for widowed women. This was partly related to age. Among men, however, only the use of sleeping pills varied significantly by marital status. There were no significant differences in consumption of tranquillizers or opiates among the four marital status categories for men.

Education and Drug Use

As levels of education increased, use of sleeping pills and tranquillizers decreased among both sexes (Table 9.2). However, opiate use increased with education levels among men, but it was not associated with education for women. Women with

less than a high school education consumed significantly more sleeping pills, tranquillizers and opiates than did their male counterparts. Women with high school or postsecondary education also consumed more of these drugs than did men, but differences were not significant in all cases. Women and men with university degrees consumed these drugs at similar rates.

Income and Drug Use

Women reported a significantly higher consumption of tranquillizers than did men in all three income categories (Table 9.3). Regarding the use of sleeping pills and opiates, no significant sex differences were found among those earning less than $20,000. However, women in higher income groups had higher rates of use than did men. Men with low incomes reported higher consumption of sleeping pills than did men with higher incomes. However, tranquillizer and opiate use among men did not vary significantly by income.

Over-the-Counter Drugs

The use of ASA and similar pain relievers was significantly greater among women than men in all categories of age, marital status, education and income (Table 9.4). Women's use of diet pills and stimulants appears to exceed that of men in all categories except postsecondary education, widowed and low income (Table 9.5). Interestingly, there do not seem to be any significant differences between the sexes in the use of opiates, such as those in the codeine/morphine/Demerol category (Tables 9.1, 9.2, 9.3). However, only one-third of the reported use in this category was nonprescription use, suggesting an extreme underreporting of use of acetaminophen with codeine (e.g., Tylenol #1).

Table 9.4

Gender Differences in Characteristics of Users[a] of Over-the-Counter (OTC) ASA or Similar Pain Relievers, Canada 1989

	Female %	Male %	Sex Ratio F:M
All	61.4*	53.5*	1.2
Age			
15–24	62.8*	53.5*	1.2
25–44	64.1*	52.8*	1.2
45–64	60.7*	48.0*	1.3
65+	52.9	49.0	1.1
Education			
Less than high school	60.8*	48.2*	1.3
Completed high school	61.0*	52.3*	1.2
Post secondary but non-university	64.4*	52.8*	1.2
University degree	64.0*	55.8*	1.1
Marital Status			
Single/never married	63.1*	50.5*	1.2
Married	61.5*	52.0*	1.2
Separated/divorced	64.2*	49.6*	1.3
Widowed	53.8	46.6	1.2
Household Income			
Less than $10,000	60.0*	46.5*	1.3
$10,000–19,000	63.8*	52.0*	1.2
$20,000–39,000	64.4*	53.5*	1.2
$40,000+	67.7*	55.4*	1.2

[a] Includes those who reported use in the past month.

* Significant sex differences ($p<0.05$).

Table 9.5

Gender Differences in Characteristics of Users[a] of Over-the-Counter (OTC) Diet Pills or Stimulants, Canada 1989

	Female %	Male %	Sex Ratio F:M
All	1.2*	0.5*	2.4
Age			
15–24	1.8	0.8	2.3
25–44	1.7*	0.5*	3.4
45–64	0.3	0.5	0.6
65+	0.4	0.4	1.0
Education			
Less than high school	1.5	0.8	1.9
Completed high school	1.1*	0.3*	3.7
Post secondary but non-university	0.7	0.7	1.0
University degree	1.6*	0.2*	8.0
Marital Status			
Single/never married	1.3	0.8	1.6
Married	1.0*	0.4*	2.5
Separated/divorced	2.9*	0.3*	9.7
Widowed	0.2	0.2	1.0
Household Income			
Less than $10,000	0.8	1.0	0.8
$10,000–19,000	1.4*	0.2*	7.0
$20,000–39,000	0.9	0.7	1.3
$40,000+	3.6*	0.6*	6.0

[a] Includes those who reported use in the past month.

* Significant sex differences ($p<0.05$).

** $n<5$

Women report using sleeping pills with greater frequency than do men. This disparity between the genders is particularly large among persons with less than high school education and among persons with high income levels. Almost all the sleeping pills used by women were obtained by prescription.

From the survey, it appears that there were fewer significant differences between the sexes in their use of OTC drugs for the over-65 age group. For all drug categories except sleeping pills, women in the 15 to 24 and the 25 to 44 age groups reported the highest frequency of use. It appears that education significantly affects the use of allergy products (Table 9.6) and sleeping pills: allergy product use was associated with higher education, whereas use of sleeping pills was associated with lower education.

Widows were least likely to use OTC drugs, except sleeping pills, which they consumed the most. Separated and divorced women used the most drugs from all OTC categories, except cough and cold products, which were used most by single women (Table 9.7). Women with low incomes reported using sleeping pills most frequently. Women earning high incomes reported the highest use of diet pills and stimulants (Table 9.5), codeine/Demerol/morphine (Tables 9.1, 9.2, 9.3) and allergy medication (Table 9.6).

Table 9.6

Gender Differences in Characteristics of Users[a] of Over-the-Counter (OTC) Allergy Medicine, Canada 1989

	Female %	Male %	Sex Ratio F:M
All	11.4*	9.3*	1.2
Age			
15–24	11.5	12.3	0.9
25–44	13.5*	10.6*	1.3
45–64	10.1*	7.2*	1.4
65+	7.4*	4.1*	1.8
Education			
Less than high school	8.9*	6.4*	1.4
Completed high school	12.3*	8.2*	1.5
Post secondary but non-university	13.1	12.6	1.0
University degree	13.9	12.7	1.1
Marital Status			
Single/never married	12.1*	10.5	1.2
Married	11.6*	9.0*	1.3
Separated/divorced	11.7	8.9	1.3
Widowed	7.8*	2.1*	3.7
Household Income			
Less than $10,000	10.0*	5.0*	2.0
$10,000–19,000	9.7	9.6	1.0
$20,000–39,000	13.9*	10.8*	1.3
$40,000+	16.3*	9.5*	1.7

[a] Includes those who reported use in the past month.

* Significant sex differences ($p<0.05$).

Table 9.7
Gender Differences in Characteristics of Users[a] of Over-the-Counter (OTC) Cough or Cold Remedies, Canada 1989

	Female %	Male %	Sex Ratio F:M
All	20.9*	23.2*	0.9
Age			
15–24	28.6	30.2	0.9
25–44	22.5*	26.1*	0.9
45–64	14.7	17.5	0.8
65+	17.3*	12.9*	1.3
Education			
Less than high school	21.1	21.2	1.0
Completed high school	21.9	24.6	0.9
Post secondary but non-university	21.0*	25.5*	0.8
University degree	20.4	23.5	0.9
Marital Status			
Single/never married	27.5	28.0	1.0
Married	18.5*	21.1*	0.9
Separated/divorced	23.9	22.6	1.1
Widowed	15.7	15.1	1.0
Household Income			
Less than $10,000	21.9	19.2	1.1
$10,000–19,000	20.4*	24.5*	0.8
$20,000–39,000	20.4*	25.7*	0.8
$40,000+	24.1	21.4	1.1

[a] Includes those who reported use in the past month.
*Significant sex differences ($p<0.05$).

Discussion

Psychotropic Drugs

Analysis of the NADS data confirms results from other studies, showing that the overall use of psychotropic drugs is low, but that women are overrepresented, especially in the use of tranquillizers and sleeping pills.

The data also clearly show a marked difference between users of opiates, such as codeine, Demerol and morphine, and users of tranquillizers and sleeping pills. Gender, age and income are the strongest predictors of differences in use, with the opiate users predominantly middle-aged and in the higher income brackets.

The issue of dependency has not been addressed in this survey. Asking respondents whether they had consumed a drug in the past 30 days may indicate a risk of dependency, but not dependence *per se*. Within this category could fall the respondent who carries Valium in her purse and takes it once a month when she feels anxious, as well as the respondent who has been taking 15 milligrams of Valium daily for several years.

The analysis of these data is also complicated because no information has been gathered on reasons for use. The one-time use of codeine for acute pain, such as that caused by a broken finger, is different from the chronic use of the drug for chronic pain, such as that caused by arthritis. Chronic use is associated with a greater risk of physiological dependence.

Although less than five per cent of the population reported using psychotropic drugs, that five per cent encompasses a wide range of use. Of considerable concern is the high level of use of sleeping pills among the elderly and, in particular, the poor elderly.

Women and Psychotropic Drug Use

Women are more likely than men to use most psychotropic drugs. There have been many feminist analyses of this issue (Penfold & Walker, 1983). One phenomenon that has been reported clinically, but that does not appear frequently in the literature, is the use of psychotropic drugs among women who are incest survivors or victims of sexual abuse or family violence (Groeneveld & Shain, 1989).

The victimization of women extends from their experience of the violence of incest or sexual abuse to how that violence is recognized and treated by society. Chemicals, however, are most often the therapy of choice prescribed

by physicians for women showing symptoms of anxiety – including women who are victims of abuse. Thus, abuse victims, through no fault of their own, often continue to suffer abuse as the result of inappropriate therapy. They may, in this manner, gain freedom from their symptoms at the expense of their self-esteem. Their history of violence may remain unheard, and their symptoms (chronic pain, gastrointestinal complaints, backaches and headaches, anxiety disorders and sleep disturbances) are likely to be missed, misdiagnosed or mistreated. Instead, benzodiazepine therapy is likely to be prescribed as a ready answer to their complaints (Jacyk, 1990). However, once their chemical abuse problem has been dealt with, victimized women receiving chemical abuse therapy often have to come to terms with the post-trauma stress of violence and exploitation.

In order to provide treatment for women who are drug dependent, it is important that more research be done on the relationship between victims of violence and drug use. Women who are victims of violence often use drugs as a way to cope while staying in a violent relationship. As well, they tend to continue using after they are out of the relationship, as they are still coping with the effects of its violence (Jacyk, 1990).

Over-the-Counter Drugs

In general, the survey supports the widely held belief that women consume more OTC medications than do men. However, the differences in consumption were not as substantial as one might expect, particularly for diet pills and stimulants. The proportion of people reporting OTC drug use in the sample population was small. Examining the data by sex, age, income, marital status and education reduced the sample size so much that meaningful interpretation was difficult.

The incidence of anorexia and bulimia in the general population is approximately 10 per cent, but 95 per cent of these cases occur in women. Considering these statistics, there may have been serious underreporting in the diet pill and stimulant category (only 43 of 6,343 women reported using an OTC diet pill or stimulant in the previous month). The low levels of reported use may partially represent a trend away from the use of diet pills to "safer" meal replacements and weight-loss programs.

Another difficulty in interpreting these results stems from the wording of the questions regarding the use of analgesics, including acetylsalicylic acid (ASA) and codeine/Demerol/morphine. It is unclear in which of these two categories the frequently used codeine-containing analgesics, such as Tylenol #1, were reported. It is also unfortunate that the phrase "used in past month" cannot differentiate between occasional and regular use or help identify appropriate or inappropriate patterns of use.

There is speculation as to why women use OTC drugs more than men do, but the subject has not been studied systematically. Historically, women have been responsible for most of the household shopping. This gives them greater exposure to OTC products available in pharmacies and other locations. Furthermore, most advertisements for non-prescription medications appear in women's magazines. Stereotypes regarding body image may affect women more than men, particularly women with higher education levels and higher incomes. These stereotypes may result in women's greater use of OTC preparations, especially diet pills and stimulants.

Conclusion

This analysis raises a number of questions. It supports the overriding evidence that women are prescribed more psychotropic drugs than are men, but is less helpful in establishing cause. Further study of drug use among adults requires more specific information on levels and duration of use, particularly to determine when the use of these drugs results in dependency.

The inappropriate use of sleeping pills by the elderly and of benzodiazepines by victims of violence also requires research. The NADS offers Canadians an opportunity to demand more research on the very important issue of psychotropic drug use among Canadian adults and, in particular, among women.

Data presented here on the use of OTC preparations support the expected trends. More detailed studies with larger samples would provide a more precise picture of the use of over-the-counter medications by Canadian women.

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CHAPTER 10

Gender Differences in Alcohol-Related Victimization: An Analysis of the 1989 National Alcohol and Other Drugs Survey

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Victimology (the study of victims) typically concentrates on those who suffer as a consequence of serious criminal acts, such as homicide, assault, robbery and rape. While these offences are serious and remain the proper focus of dominant interest, the examination of damages resulting from less serious offences is appropriate when attempting to assess the risk level of subpopulations for serious victimization. Moreover, theories and research that increase our understanding of harmful predatory acts may be used to explain the causes of offences of a less harmful nature.

When alcohol is involved, the range of possible victimization is great: an individual may be merely annoyed by offensive drinking behavior or may experience permanent physical, social and financial harm. A sample survey of a general population would reveal few respondents who have been victims of criminal offences, alcohol-related or otherwise. A survey, however, would uncover many respondents who have suffered alcohol-related consequences that are relatively minor in terms of degree of damage. An assessment of these respondents should indicate sectors of the population at risk for more critical damage from drinking by others.

The 1989 National Alcohol and Other Drugs Survey (NADS), conducted by Health and Welfare Canada, provides an opportunity to assess the distribution, in a large sample population, of negative experiences resulting from alcohol use by others. In this analysis, we pay special attention to differences in the incidence and antecedents of alcohol-related damage in men and women. Another main issue is the extent to which respondent characteristics, attitudes and behaviors affect gender

differences in experiencing adverse outcomes of others' drinking. Analyses of factors that predict the prevalence and types of alcohol-related consequences should contribute to knowledge about victimization and the impact of alcohol use in different sectors of the Canadian population.

Victim Characteristics

Concerning criminal victimization, the typical victim resembles the typical offender. Both parties (victim and perpetrator) involved in crime are likely to be male, young, and urban residents (Canadian Urban Victimization Survey, 1983, Department of the Solicitor General, 1983-85; Sacco & Johnson, 1990). There is variation in the types of victims according to the types of offences. Women are far more likely than men to suffer sexual assault, while men are more likely to be physically assaulted or robbed (Canadian Urban Victimization Survey, 1983, Department of the Solicitor General, 1983–85). Across studies, there is an inverse relationship with age: young people are at greater risk for most types of crimes. The combination of age, aspects of lifestyle, and proximity to high-crime areas (e.g., the inner city) is found to be highly associated with criminal victimization (Cohen, Kluegel & Land, 1981).

Being married has been associated with decreased likelihood of victimization (Cohen & Felson, 1979; Canadian Urban Victimization Survey, 1983, Department of the Solicitor General, 1983-85; Sacco & Johnson, 1990); women, however, were more often victims of marital violence than were men (Sacco & Johnson, 1990; Kantor & Straus, 1989; Welte & Abel, 1989). Income level does not appear to have a consistent relationship to the probability of being victimized, but some analyses suggest that individuals with higher income levels are more frequently victims of larceny and household robbery than are those with lower levels of income (Cohen, Kluegel & Land, 1981; Sacco & Johnson, 1990). Analyses also suggest that interpersonal offences of a more violent nature occur more frequently to those with lower rather than higher incomes (Canadian Urban Victimization Survey, 1985; see Department of the Solicitor General, 1983–85).

Explanations of Victimization Rates

Explanations of differences in victimization rates identify biosocial, geographic and behavioral factors that either protect against or increase the risk of harm. Cohen, Kluegel and Land (1981) identify age and lifestyle as factors that strongly affect the chance of being victimized. Youth is associated with social activities and exposure to situations that increase the chances of troublesome encounters. Lifestyle factors include day-to-day activities that leave individuals open to either greater or lesser risks of exposure and vulnerability to criminal acts. While increased social activity outside the home relates directly to exposure, such factors as marriage, strong neighborhood community, and more routinized patterns of work and leisure increase the "guardianship" factor, protecting against the likelihood of victimization (Hindelang, Gottfredson & Garofalo, 1978).

Other analyses suggest that crime protection resources (e.g., the presence of police) are unequally distributed in a population – in much the same way as income or other socioeconomic attributes are unequally distributed – and may affect rates of victimization (Quinney, 1975). There is little support, however, for a consistent relationship between income and victimization. Where there is such an association, the relationship is direct:

a well-to-do target is more attractive than a poor one (Cohen, Kluegel & Land, 1981). Concerning cases involving violence, which are more concentrated among the less advantaged, factors other than income play a role in precipitating crimes.

The idea of "victim precipitation" was introduced by Wolfgang (1958) in his interpretation of patterns of homicide in Philadelphia. The concept views crime as an interaction between the offender and the victim, the latter being, in part, responsible for causing his or her victimization. Schafer's explanation of the concept (1968) is explicit with regard to the possibility that the victim contributes to the occurrence of the offence:

> *Many offenders are offended by the victim, or, better, many victims victimize the offender: thus, the doer–sufferer distinction does not mean the exclusive doing of one party and the suffering of another.*
>
> *(Schafer, 1968:102)*

Silverman (1973) elaborated on the victim's contribution to a crime by focusing on the offender's perceptions as opposed to the researcher's. From the offender's point of view, the victim can be provocative or vulnerable, or behave in such a way as to provoke the offence. From the victim's point of view, such provocation on the part of the victim may be conscious or unconscious, intended or unintended. In short, the ways in which the victim may contribute to the offence are varied and complex.

There has been criticism of these victim precipitation models of crime from feminist perspectives. "Blaming" female victims because of the possibly provocative nature of their behavior stereotypes women and allows abnormal male behavior to escape blame (Stanko, 1985).

Walklate (1989) takes issue with dominant perspectives on victimization, because they do not take into account the dynamics within the home and family or the power differences that may affect a person's likelihood of being victimized.

Alcohol and Victimization

A large variety of antisocial experiences, including crimes, are very likely to involve alcohol. Early studies in Philadelphia show the presence of alcohol in homicide (Wolfgang, 1858) and rape cases (Amir, 1967). More recent investigations show substantial involvement of alcohol in cases of assault (Shepherd, Irish, Scully & Leslie, 1989; Gerson, 1978), traffic deaths, accidents and suicides (Haberman & Baden, 1974; Abel & Zeidenberg, 1985; Welte & Abel, 1989). Fillmore (1985) notes the involvement of alcohol in less serious, but more frequently occurring social experiences, such as insults, harassment and destruction of property.

When alcohol use has been of concern in research on victimization, the focus has often been on the drinking behavior of the victim. Recent Canadian data show an association between the extent of alcohol use and levels of violent victimization (Sacco & Johnson, 1990). Likelihood of multiple victimization is also associated with levels of alcohol consumption (Lasley & Rosenbaum, 1988; Williams & Singh, 1986; Fillmore, 1985).

Aside from alcohol use, lifestyle behaviors may increase victimization rates. Kennedy and Forde (1990) reported decreased victimization rates among older, married people. They speculated that older, married people probably spend less time in bars than others and are therefore less likely to be exposed to circumstances in which victimization occurs. Adrian (1989), for example, has reported that barbrawl murders in Canada entail a preponderance of fights between strangers. There

was no known relationship between most of the victims and their murderers, suggesting that the combination of drinking and other aspects of bar situations may result in spontaneous aggression. Williams, Singh and McGrath (1985) documented an association between bar attendance and gun-involved victimization.

Gender, Alcohol and Victimization

Men are more frequent victims of interpersonal violence involving alcohol than are women. Male victims also tend to have used alcohol or have been intoxicated at the time of an incident to a far greater extent than female victims (Abel & Zeidenberg 1985; Shepherd, Irish, Scully & Leslie, 1989; Welte & Abel, 1989). For crimes such as spousal assault and rape, where the victim is usually a woman, alcohol involvement exists, but its role in the situation is complex and, for the most part, unspecified. While most incidents of rape and spousal assault do not entail drinking (Kantor & Straus, 1989, 1990; Richardson & Hammock, 1991), those who use alcohol are more often offenders and victims than are non-drinkers. The drinking and drug problems of the husband were important predictors of wife victimization in a U.S. National Family Violence Survey (Kantor & Straus, 1989). However, there is also evidence that drinking, problem drinking and intoxication by the female victim increases the probability of assault (Eberle, 1982; Kantor & Straus, 1989). Likewise, drinking and intoxication by female victims show up in rape cases with considerable frequency (Amir, 1967; Johnson, Gibson & Linden, 1978; Richardson & Hammock, 1991).

Fillmore's (1985) study of Berkeley residents employs a more encompassing definition of alcohol-involved victimization. It revealed that women as a whole were slightly more likely than men to be harassed, have family/friend problems and multiple problems as a result of someone else's alcohol use. Women who reported drinking heavily or having drinking problems had higher rates of all types of victimization than did men. Moreover, regardless of the level of alcohol use, regular visits to bars (once a month or more) were associated with higher victimization rates for women than for men.

Research Questions

This analysis of the relationship between drinking and victimization aims to specify the relative importance of individual attributes in contributing to the risk of victimization. Using multivariate statistical techniques, we analyze results from the 1989 National Alcohol and Other Drugs Survey (NADS) to isolate specific factors that appear to increase risk or to protect against the consequences of drinking by others. The contribution of gender is of particular interest.

Respondents to the NADS were questioned about negative consequences that may be considered minor (arguing and being disturbed or insulted) as well as consequences of a more serious nature that have the potential to result in permanent damage (riding with a drunk driver, having an auto accident, or being involved in a physical fight). Respondents were also questioned about financial and family problems due to others' alcohol use. Consideration of these problems allows for the identification of a wide range of alcohol-related troubles. While we cannot assess rates of more serious or criminal offences, which are the usual concerns of victimization studies, these data allow for the identification of subpopulations that are particularly vulnerable to damage associated with alcohol use. We address the following questions:

- To what extent are members of the Canadian population adversely affected by others' alcohol use? Are there differences in the rates of experiences of the genders? Are there gender differences in the types of alcohol-related consequences experienced?

- How important is gender in predicting overall alcohol-related victimization and types of victimization?

Methods and Procedures

This study used multiple regression techniques to examine the relationship between the degree and type of victimization (response variables) and the factors that may affect victimization (predictor variables), including demographic factors, levels of alcohol use, presence or absence of alcohol problems among close associates, and respondents' activities and attitudes.

Response Variables

The original questionnaire item asked respondents about whether they had experienced specific types of victimization as a result of someone else's drinking sometime in their life and during the past 12 months (Table 10.1). Because most information employed as predictor variables was not available for lifetime experience (e.g., age, marital status), and since victimization sometime in a respondent's life would be affected by age, this analysis considered only the responses pertaining to victimization during the past year.

The types of victimization experienced as a result of other people's drinking problems considered in this study included:

- being insulted or humiliated by someone who had been drinking and/or having serious arguments or quarrels as a result of someone else's drinking (referred to as *insulted/argued* in this chapter). Although there were originally two separate variables for "being insulted or humiliated" and "having serious arguments or quarrels," the results of bivariate and multivariate analyses indicated very similar distribution patterns and relationships with the predictor variables. Moreover, it is likely that the two items conveyed similar meanings to the respondents. Consequently, they were combined as one variable, *insulted/argued*, to indicate either of the two types of victimization.

- having friendships break up as a result of someone else's drinking (*lost friends*)

- having family problems or marriage difficulties due to someone else's drinking (*family/marital* problems)

- being a passenger with a driver who had too much to drink (*drunk driver*)

- being in a motor vehicle accident because of someone else's drinking (*auto accident*)

- having the respondent's property vandalized by someone who had been drinking (*vandalized*)

- being pushed, hit or assaulted by someone who had been drinking (*assaulted*)

- being disturbed by loud parties or the behavior of people drinking (*disturbed*)

- having financial trouble because of someone else's drinking (*financial trouble*).

In addition, *total victimization* (i.e., total number of victimizations experienced) was created on the basis of the 10 victimization variables (minimum = 0, maximum = 10). Logarithmic transformation was necessary to reduce the degree of non-normality and outliers.

Table 10.1

Percentage of Respondents who Reported Experiencing Specific Types of Victimization as a Result of Someone Else's Drinking for Each Gender and the Entire Sample

	By Sex			Total	
Victimization Type	Sex	Count	Percentage	Count	Percentage
Insult/argument	Female	906	27.9	1816	28.0
	Male	910	28.2		
Loss of friendship	Female	235	7.2	423	6.5
	Male	188	5.8		
Family problems	Female	407	12.5 } **	563	8.7
	Male	156	4.9		
Drunk driver	Female	297	9.1 } **	726	11.2
	Male	429	13.3		
Auto accident	Female	22	0.7 } *	66	1.0
	Male	45	1.4		
Vandalism	Female	130	4.0	235	3.6
	Male	105	3.3		
Assault	Female	182	5.6 } **	480	7.4
	Male	298	9.2		
Disturbance	Female	948	29.2	1847	28.5
	Male	899	27.9		
Financial trouble	Female	77	2.4 } *	125	1.9
	Male	48	1.5		

Note: n = 6,474 for the entire sample: 3,248 for females, 3,225 for males (weighted by effective sample size).

* $p<.01$

** $p<.0001$ (significant gender difference based on Pearson chi-square test)

Predictor Variables

As predictor variables we considered:

1. Respondents' demographics
   a. Sex; 1=male, 0=female.
   b. Age; midpoint of five-year intervals ranging from 17.5 to 82.5.
   c. Marital status; 1=with a partner/spouse, 0=without a partner/spouse.
   d. Household income; midpoint of nine categories ranging from 0 to 60 ($1,000).

2. Drinking problems among close associates; 1=presence, 0=absence.
   a. Partner.
   b. Family/relatives.
   c. Friends.
   d. Co-workers.

3. Respondents' activities and attitudes related to alcohol use.
   a. Social activities; sum across variables indicating the frequencies of activities included in Questions 14 and 15 or 25 and 26, excluding "quiet evening at home"; mean=229.9, s.d.=169.3, min=0, max=1324.
   b. Bar visits; number of visits to bar or tavern in the past year; mean 12.6, s.d.=31.1, min=0, max=156.
   c. Tolerance of drunkenness; sum of items in Question 51; mean 15.2, s.d.=3.7, min=8, max=32.

4. Respondents' alcohol use in the past 12 months.
   a. Quantity-frequency; total number of drinks consumed based on the frequency of drinking and the usual number of drinks; mean=189.9, s.d.=430.5, min=0, max=10220.
   b. Maximum per occasion; mean=4.8, s.d.=5.4, min=0, max=98.

The selection of the predictors was informed by the prior research discussed above. Because the effect of gender is a primary consideration, interaction between sex and all the other predictors was examined. The order in which these sets of predictors are listed reflects the causal directions assumed: demographics and drinking problems among close associates are presumed to affect respondents' activities and attitudes, which in turn affect their alcohol use.

Data Analysis[1]

The SPSS Release 4.0 for Sun 4 was used for linear regression, and BMDP Version 1990 (Sun/Unix) for logistic regression. The data were weighted to adjust for survey design effects and population characteristics. The sample was split into two subsamples at random: the first learning subsample was used to build all the regression models, which were verified using the second validation subsample.

The log-transformed total victimization was submitted to a multiple linear regression analysis, while all the dichotomous response variables pertaining to the specific types of victimization were put through logistic regression. Hierarchical entry of predictors was dictated by the order of causal directions postulated above. After all four sets of predictors were in the model, the forward selection method was employed to include only interaction terms that were significant.

Results

In the sample, 48 per cent experienced some victimization due to someone else's alcohol use in the past year, including 46.7 per cent of the women and 49.3 per cent of the men.

For each of the nine types of victimization, Table 10.1 presents the percentage of individuals in the study who indicated the particular victimization, and this is further displayed by gender. Being disturbed and having interpersonal problems (*insulted/argued*) were reported most frequently by both sexes. Using a chi-squared test for independence of gender and victimization, Table 10.1 also summarizes differences between the genders in the victimization categories. Half of the types of victimization had no significant gender differences. Women reported significantly higher rates than men for *family problems* ($p<.0001$) and *financial trouble* ($p<.01$) due to someone else's drinking. Men had statistically higher rates for riding with a *drunk driver* ($p<.0001$), for having had an *auto accident* ($p<.01$) and for *assault* ($p<.0001$). These results would appear to provide strong support for the hypothesis of the existence of gender differences in these categories of victimization.

Table 10.2 shows the examination of associations between the nine categories of victimization for each gender as a first step in determining whether any patterning of consequences exists and whether there may be significant differences between the sexes. This table displays the phi coefficients of association for the categories of victimization for each gender.

For both males and females, there were relatively high correlations (*phi*>.300) between interpersonal problems (*insulted/argued*) and riding with a *drunk driver*. Relatively high associations also occurred between interpersonal problems and physical *assault* for both sexes. Overall, correlations appeared higher for women than for the corresponding associations for men, suggesting that victimization for women may be more "holistic," or generalizable to more areas of life. For women, verbal fights were associated with alcohol-related trouble in friendships and in family to a greater degree than was true for men.

Differences in the male/female correlations were tested using log-linear models with a three-way interaction term representing gender by each of two categories of victimization. Only two significant gender differences were obtained. The correlation between *family/marital* problems and *insulted/argued* differed for men and women, with females indicating a stronger correlation (.452) than was found for males (.235); based on a weighted sample size of n=6,474, the three-way likelihood ratio chi-squared with one degree of freedom (1 d.f.) was 8.758 ($p=.0031$). Similarly, there was a stronger correlation between *family/marital problems* and *financial trouble* for females (.331) than for males (.148). Here the three-way likelihood ratio chi-squared with 1 d.f. was 11.137 ($p=.0008$).

Table 10.2
Phi Coefficients of Association Between Pairs of Victimization Variables for Each Gender

		Variable							
Variable/ Victimization Type	**Sex**	C	D	E	F	G	H	I	J
AB Insult/ argument	Female	.348	.452*	.332	.048	.187	.348	.301	.221
	Male	.277	.235	.310	.084	.172	.396	.240	.090
C Loss of friendship	Female		.309	.189	.026	.140	.214	.213	.185
	Male		.183	.146	.113	.122	.228	.154	.174
D Family/marital problems	Female			.278	.020	.124	.232	.153	.331**
	Male			.113	.022	.093	.116	.129	.148
E Drunk driver	Female				.107	.174	.292	.148	.203
	Male				.125	.151	.195	.162	.111
F Auto accident	Female					.094	.083	.045	.086
	Male					.076	.106	.062	.079
G Vandalism	Female						.230	.184	.138
	Male						.217	.102	.136
H Assault	Female							.199	.236
	Male							.137	.146
I Disturbance	Female								.090
	Male								.069
J Financial trouble	Female								
	Male								

Note: N = 3,248 for females, 3,225 for males
* $p<.01$
** $p<.001$ (significant gender difference based on loglinear analysis of 3-way classification).

Table 10.3
Hierarchical Linear Regression Analysis of Total Victimization

Predictor Variable	r	R-square change	b	beta
Sociodemographic		.118**		
Sex	-.020		.0154	.0126
Age	-.338		-.0185	-.4808**
Age-squared	-.323		.0001	.2810**
Marital status	-.120		-.0067	-.0051
Income	.032		.0000	-.0341
Drinking problems		.201**		
Partner	.238		.8576	.2030**
Family-relatives	.290		.2279	.1537**
Friends	.375		.3163	.2197**
Co-workers	.232		.1607	.0977**
Activities and attitudes		.024**		
Social activities	.238		.0003	.0862**
Bar visits	.245		.0012	.0600**
Tolerance	.202		.0040	.0234
Alcohol use		.011**		
Quantity-frequency	.100		.0000	-.0068
Maximum per occasion	.274		.0337	.3074**
Interaction		.005**		
Sex by maximum	.159		-.0221	-.2111**
Intercept			.6799	

Note: Model obtained from the learning subsample; n=3,150 weighted by the final weight scaled down to the sample size, and further adjusted for the average design effect. The dependent variable total victimization was natural-log transformed in order to reduce the degree of non-normality and the number of outliers. Forward selection with entry criterion of $p<.01$ was used in the last stage to select the interaction terms. $R2 = .359$ for the learning subsample and .357 for the validation subsample (n=3324). *p<.01. **p<.001.

Predictors of Total Victimization

To address the question of which characteristics were related to victimization, a multiple regression model relating *total victimization*, as measured by this newly constructed variable, to the predictor variables was carried out; the results are shown in Table 10.3.

The results displayed in Table 10.3 address the question of differential distribution of the overall victimization. The dependent variable, *total victimization*, was based upon a count of the number of different types of negative social consequences reported by respondents during the past year. The discussion above concerning previous research informed the ordering of entry of the sets of predictors. Demographic characteristics define social location and attributes, and the set of demographic predictors was entered in the first stage of the regression analysis. Predictors indicating the presence or absence of drinking problems among close associates were entered in the second stage, and those concerning alcohol-relevant attitudes and behaviors were entered in the third stage. The fourth-stage predictors were two measures of the respondents' drinking: a quantity-frequency measure and the maximum number of drinks upon one occasion during the past year. In the final stage, interactions between *sex* and all the other predictors were put through the forward selection procedure so that only those meeting the $p<.01$ significance criterion would be included in the final model.

The linear regression model predicted 35.7 per cent of the variance in *total victimization*. The sociodemographic set accounted for 11.8 per cent when entered by themselves in the first stage. *Sex* did not make a significant contribution in the final model. Age (*beta* = –.2019, $p<.001$) and income (*beta* = –.0441, $p<.01$) were significant predictors. The associations were inverse; younger respondents and those with lower incomes reported a greater number of types of alcohol-associated harm.

Of particular note, but not surprising, is the substantial contribution to *total victimization* of the second set of predictors when added to the demographic set ($R^2=.197$, $p<.001$). All variables in this set were significant in the final model, indicating that those who had partners, family members, friends and/or co-workers with drinking problems reported more types of negative social consequences as a result of drinking by others.

Alcohol-related activities and attitudes explained a small but significant proportion of the variance in the third stage of variable entry ($R^2=.025$, $p<.001$). All predictors in this set were significant, indicating that a greater degree of social participation, more frequent bar attendance and tolerance of drunkenness increased vulnerability to alcohol-involved victimizations.

The respondent's *maximum* number of drinks on any one occasion was positively associated with total *victimization*, but *quantity/frequency* was not significant in this analysis. The result suggests that people who drink heavily upon given occasions are more vulnerable to harm from drinking than others. However, total volume of alcohol consumed (as indicated by the estimated number of drinks per year) does not affect the number of types of harm, when controlled for all the other predictors.

Sex by maximum was the only interaction term which made a significant contribution to the variance after the entry of all predictors ($R^2=.005$, $p<.001$). While an increase in the *maximum* amount drunk is associated with an increase in *total victimization*, the slope, or rate of increase, is steeper for women with each unit increase in the *maximum*. In this case, the unit increase means each additional reported drink.

Predictors of Specific Victimization

This section of the study examines the statistical odds of an individual's being victimized in a specific way, and seeks to discover what factors statistically increase or decrease an individual's odds of being so victimized. To carry out this part of the study, a number of procedures are necessary: having examined the issue of total victimization and having earlier noted that different patterns might be related to different categories of victimization, logistic regression models were developed for each category of victimization, using the sets and stages of predictor variables initially entered in the multiple regression model for *total victimization*. Again, the models were developed using the learning samples and verified using the validation sample.

Table 10.4 presents model chi-squares and significance for each stage of the analysis of seven criteria, or specific victimizations, as well as Hosmer-Lemeshow goodness-of-fit chi-square statistics and percentages of respondents reporting victimization which the model classified correctly. The results on *auto accident* and *vandalism* are not included here because the models were not acceptable in terms of correctly classifying respondents. Hosmer-Lemeshow statistics indicated a poor fit of the models for *family/marital* and *disturbance*, and the results should be interpreted with caution.

It is clear that the sets of sociodemographic predictors and drinking problems among close associates made statistically significant contributions across the range of specific victimizations. Drinking problems of people who are close are especially associated with problems in social interaction (*insult/argument* and *family/marital* problems). The behavior and attitudes of the respondents were directly related to five of the seven specific victimizations: *insulted/argument*, *family/marital*, riding with a *drunk driver*, *assault* and *disturbance*.

The analysis in Table 10.4 also shows that alcohol use by the respondent is significantly related to *insults/arguments*, *family/marital* problems, riding with a *drunk driver*, and *financial trouble* during the past year. There were three models that included significant interaction terms, all of which involved drinking measures.

Logistic regression involves modelling log-transformed odds for reporting victimization of a specific type, and the resulting coefficients are more interpretable when translated into odds multiplication factors, which are presented in Table 10.5 together with the observed overall odds for each of the response variables. For example, the odds for *insult/argument* increases by a factor of 14.1 if the respondent's partner has a drinking problem, and decreases by a factor of $.968^{40}=.272$ when a 62-year-old is compared with a 22-year-old, always assuming equal values on all the other predictors.

As a main effect, the gender of the respondent was a significant independent predictor in two of the logistic regression models presented in Table 10.5. Women are 3.5 times (1/.282) more likely to report *family/marital* problems as a result of someone else's drinking during the past year, and men are almost 2.5 times more likely to report *assault*. The age of the respondent was significant in all models: the younger the respondent, the more likely he or she was to report all the victimizations considered in the analysis. The odds for *assault* were significantly higher for single than for married respondents, and lower income increased odds for reporting friendship loss (*lost friends*) as well as *assault*.

Table 10.4

Model Chi-Squares for Each Stage, and Hosmer-Lemeshow Goodness-of-Fit Chi-Squares of the Final Models Obtained from Hierarchical Logistic Regression Analysis of the Specific Types of Victimization, and Percentages of Respondents Correctly Classified by the Final Models

Predictor variable	df	Insult/ argument	Lost friends	Family/ marital	Drunk driver	Assault	Distur-bance	Financial trouble
Sociodemographic	4	252.7**	61.0**	144.0**	213.5**	184.6**	109.5**	33.9**
Drinking problems	4	360.9**	168.7**	437.9**	192.6**	155.0**	188.0**	128.7**
Activities and attitudes	3	86.2**	6.8	11.8*	77.8**	16.0*	12.7*	0.8
Alcohol use	2	69.6**	3.7	21.1**	45.4**	9.0	4.2	13.8*
Interaction								
Sex by maximum		10.5*	–	–	–	–	–	–
Sex by Q-F		–	–	–	26.0**	19.6**	–	–
Hosmer-Lemeshow chi-squares	8	8.1	11.0	20.2*	12.7	16.8	23.9*	18.8
Percent correctly classified among those reporting the event								
Learning subsample		46.6	45.5	68.1	57.9	60.7	30.7	81.8
Validation subsample		42.5	45.8	63.3	55.1	49.2	24.0	78.1

Note: n=3,150 weighted by the final weight scaled down to the sample size, and further adjusted for the average design effect. Each model was built on the learning subsample, and verified on the validation subsample. Significant Hosmer-Lemeshow statistics indicate poor fit of the final models. Classification criterion was at the point where 10% of false positives occurred for those not reporting the specific type of victimization.

*$p<.01$.

**$p<.001$.

Table 10.5
Odds Multiplication Factors of the Predictors in the Final Logistic Regression Models for the Specific Types of Victimization in the Learning Subsample

Predictor variable	Insult/ argument	Lost friends	Family/ marital	Drunk driver	Assault	Distur- bance	Financial trouble
Sociodemographic							
Sex	.977	.748	.282**	1.459	2.427**	.925	.737
Age	.968**	.978**	.969**	.954**	.946**	.976**	.962*
Marital status	1.053	.793	1.032	.738	.569*	1.244	.706
Income	1.000	.980**	.994	.994	.987*	.996	.980
Drinking problems							
Partner	14.138**	3.986**	46.096**	15.911**	9.655**	3.084**	56.651**
Family-relatives	2.044**	2.401**	6.935**	1.147	1.487	1.431**	2.809*
Friends	2.204**	3.095**	3.307**	2.981**	2.027**	2.235**	1.525
Co-workers	1.868**	1.565	.938	.750	2.492**	1.534**	1.094
Activities and attitudes							
Social activities	1.001	1.001	1.000	1.001	1.001*	1.001**	1.000
Bar visits	1.009**	1.00	.996	1.005*	1.000	.999	.992
Tolerance	.998	.963	1.051	1.047	1.007	1.005	.969
Alcohol use							
Quantity-frequency	1.000	1.000	1.0009**	1.002**	1.002**	1.000	1.001**
Maximum per occasion	1.170**	1.030	1.035	1.065**	1.034*	1.002	1.024
Interaction							
Sex by maximum	.923*						
Sex by Q-F				.998**	.998**		
Observed odds	.3560	.0696	.0926	.1250	.0788	.4073	.0191

Note: n=3150 weighted by the final weight scaled down to the sample size,and further adjusted for the average design effect. The observed odds were computed by dividing the number of respondents reporting the victimization by the number of respondents not reporting. For each unit increase in the predictor, when controlled for all the other predictors, the odds are multiplied by the odds multiplication factor tabled here.

*$p<.01$.

**$p<.001$.

Reporting close associates with drinking problems significantly and independently increased odds of reporting all types of victimization during the past year. The differential effects of types of associates, as well as the magnitude of increases in the odds of victimization, are worth noting. Having a partner who drinks too much increased the chances of reporting *family/marital* problems 46 times and *financial trouble* 57 times. Odds of other negative consequences were also greatly increased when the respondent reported having a partner who drank too much. Effects of family members other than the partner, of friends and of co-workers upon the odds of reporting a range of troubles during the past year were also considerable.

Odds of reporting *assault* and *disturbance* increased with the amount of social activity. The number of visits to bars during the past year was associated with increased odds of reporting *insult/argument* and riding with a *drunk driver*. Tolerance of drunkenness made no independent contribution to the odds of reporting any type of victimization in the final model.

The respondent's alcohol use made independent contributions to the prediction of several types of negative social consequences during the past year. The greater the estimated number of drinks during the past year (*quantity-frequency*), the greater the odds of the respondent's reporting riding with a *drunk driver*, *assault* and *financial trouble*. The higher the reported *maximum* number of drinks per occasion, the higher the odds of reporting *insult/argument*, riding with a *drunk driver* and *assault*. While the odds for these alcohol consumption measures may seem small compared with those for close associates with drinking problems, it is important to note the differences in the nature of the predictors. Predictors referring to close associates with drinking problems are dichotomous variables, while the alcohol consumption variables are continuous and cover a wide range of values (see the description of predictors in the methods section), each unit referring to one drink.

The respondent's alcohol use had differential effects upon the likelihood of reporting some of last year's troubles, depending upon the sex of the respondent. Reporting a greater maximum number of drinks upon an occasion increased the likelihood of women's involvement in *insult/argument* more than it did for men. Moreover, increases in *quantity/frequency* had a greater impact upon increasing odds for women riding with a *drunk driver* and *assault* than it did for men.

Conclusion

The main limitation of these findings is that they give rise to questions that have no response, because the data set does not contain information about the offender. It would be advantageous to have some data on the perpetrators of insults, assaults and disturbances, and on the relationship of the drunken driver to the respondent. On the other hand, the NADS represents a good beginning to the exploration of alcohol-involved victimization on a national scale, and identifies a wide range of negative social consequences. A limitation of this analysis is that it is, for the most part, exploratory, because of a lack of well-developed theory that would have informed an authoritative methodology.

Gender

The descriptive data presented in Tables 10.1 and 10.2 correspond to the results of previous research in victimization and alcohol-related consequences. Differences

between women's and men's experiences were as expected: women were more likely to report trouble closer to home in family and finance, while men were more subject to risk of physical damage from motor vehicles and assault. The greater clustering of alcohol effects for women also confirms a stereotype of their social existence as interpersonal and related, as opposed to that of men, which is held to be more segmented (e.g., Chodorow, 1989; Gilligan, 1982). That men and women face different types of victimization at different rates is a valid finding, but more elaboration is needed to explain the processes that produce these rates.

While there are variations in gender rates, the issue of gender *effects* is more complex. Unlike age, gender on its own (i.e., as a main effect) contributed to the prediction of only two negative consequences of others' drinking. Women had higher odds of reporting problems in the family and marriage, and men were more likely to report having been assaulted during the year prior to the survey.

Although interaction terms with gender and all other predictors were entered in the analyses, the only terms that made a significant contribution to any of the models were those with gender and alcohol consumption. The results suggest that women were more vulnerable than men to negative experiences from others' drinking as the women increased their alcohol use. The dynamics of enhanced vulnerability of women who drink heavily merit further study.

Predicting Alcohol-Related Victimization

Prior research indicates that being male, young and single is associated with victimization risk. The multivariate analysis in this study suggests that gender and marital status play a far less important role in alcohol-related victimization than has been proposed. Age was the only demographic variable to appear reliably as an important predictor of overall and specific victimization, suggesting that youth alone (unlike gender, where effects were conditional) is associated with risk of victimization.

Drinking problems among close associates were by far the most important factors predicting alcohol-involved victimization. This suggests that much alcohol-related trouble is beyond most people's control, insofar as it is difficult to avoid one's family, friends and co-workers. Theories of criminal victimization that emphasize a guardianship factor as protection – with marriage, strong neighborhood community and more routinized patterns of work and leisure protecting an individual against victimization – do not apply to protecting against damage resulting from alcohol-related situations when the guardians abuse alcohol.

In this study, a number of factors, such as measures of alcohol use, frequency of social activities and bar attendance predicted victimization. These factors may be indicators of the theory of victim precipitation or the likelihood that an individual may be contributing to his or her risk of being victimized. Respondents' drinking behavior significantly predicted troubles from others during the previous year. The higher the maximum amount drunk on any one occasion, the greater the likelihood of reporting more types of harm and being insulted or having arguments. The likelihood of these troubles was particularly high when women drank more heavily. The greater the total volume of alcohol intake, the greater the risk of problems in family and finances because of someone else's drinking. Both total volume and maximum intake measures made independent contributions to the probabil-

ity of having been a drunk driver's passenger and having been assaulted by someone who drank too much. Women reporting higher total volume were particularly susceptible to these risks.

Social activities and bar attendance made some contributions to predicting victimization, but their effects were not nearly as strong as the effects of close associates and drinking behavior.

This study has differentiated gender effects from gender rates, and has found few gender effects. We suggest that the sources of gender-associated differences are behaviors and lifestyles. Thus, when men and women socialize and drink in the same ways, they risk similar consequences.

Notes

1. For discussion of terms related to statistics and data analysis, see the Glossary.

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CHAPTER 11

Predictors of Drinking among Canadian Women and Men

June Chaikelson

Patterns of Alcohol Use

Alcohol research literature has traditionally focused on alcoholism and alcohol problems. The frequency of alcoholism in women is generally found to be substantially lower than the frequency in men. For example, Robins, Helzer, Przybeck and Regier (1988), in the Epidemiological Catchment Area studies of five sites in the United States – which included 20,000 adults from households and institutions – found significantly lower rates of alcoholism for women. The male to female ratios averaged across sites were 4.1 for a young adult group, 6.3:1 for a middle-aged group, and 9.7:1 for the oldest group.

Studies limited to alcoholics will never help eradicate the problems that the excessive use of alcohol causes for society, because much of the associated cost is attributable to those who do not meet the formal medical criteria for a diagnosis of alcoholism (Hawks, 1989). Thus, beginning in the late 1960s, special emphasis was given to studying the effects of social or moderate drinking. This research approach came into prominence with the publication of a national probability survey in *American Drinking Practices* (Cahalan, Cisin & Crossley, 1969). The general finding in all the survey literature is that women drink less than men, and older adults of both sexes drink less than younger adults (e.g., Cahalan, Cisin & Crossley, 1969; Andrews, 1988; Health and Welfare Canada, 1984, 1989a, 1989b; National Center for Health Statistics, Schoenborn & Cohen, 1986).

The National Alcohol and Other Drugs Survey (NADS) conducted during March 1989 by Health and Welfare and Statistics Canada questioned Canadians

about their use of alcohol and other substances. The NADS confirmed earlier findings that fewer women than men drink and that those who do drink consume smaller quantities. There were significant differences between the proportion of women and men who could be classified as lifelong abstainers (nine per cent vs. four per cent), former occasional drinkers (0 drinks in the last 12 months – 16 per cent vs. six per cent), former regular drinkers (three per cent vs. six per cent), and current drinkers (72 per cent vs. 84 per cent). Thus, compared with men, women were more likely to be lifetime abstainers and former occasional drinkers, and less likely to be former regular drinkers and current drinkers.

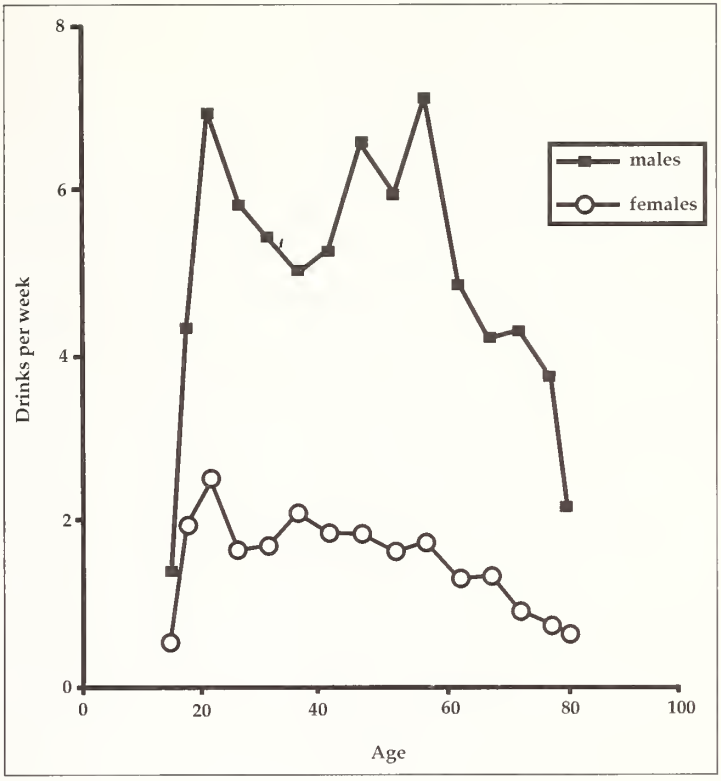
Most studies find more abstainers among women at all ages and, in general, the proportion of the population claiming abstinence increases with age (Hilton, 1987). This trend also holds true in the NADS, where the highest level of abstinence (25 per cent) was reported by women over 70. The incidence of alcohol use among adolescents is very high; in the NADS only nine per cent of females and eight per cent of males aged 17 to 19 years reported abstinence. This finding is comparable to that of Oetting and Beauvais (1990), who reported that, by the end of high school, fewer than eight per cent of students in the United States reported abstinence.

There is clearly a cohort effect in alcohol use among women (i.e., the alcohol use of a given generation of women continues throughout the life course of its members). Hilton (1986) found an apparent drop in the abstinence rate for young women in their twenties, with the drop continuing for a 15-year period. The finding of an increase in alcohol use among women in the student and young adult population provides some support for the convergence hypothesis (Hilton, 1986), which predicts that while the use of alcohol is generally on the increase, women's drinking levels are increasing disproportionately and thus approaching the levels recorded for men. Although no direct test of the convergence hypothesis is possible with cross-sectional survey data, a similar drop in the abstinence rate was noted in the NADS. In the NADS, the abstinence rate for women age 20 years was five per cent. The rate continued at about that level for 25 years – 10 years longer than in Hilton's report. It then increased to 10 per cent for women aged 45 to 49. No such trend is found for men.

Not only did a greater percentage of women than men in the NADS survey report abstinence, but those who did drink also reported taking fewer drinks per week. To examine the quantity of alcohol use as a function of sex and age for drinking subjects, a quantity-frequency alcohol consumption variable of drinks per week was calculated by multiplying quantity by frequency of use. As can be seen in Figure 11.1, at all age levels women drink fewer drinks per week than men.

In addition to the comparison of reported alcohol use by women and men, the NADS data provided an opportunity to look at predictors of alcohol use in a large epidemiological study. In the NADS, demographic information on age, education, employment status, marital status and income was gathered, as well as a global rating of health, social support and stress. Respondents were also asked to provide information on alcohol use by family members and friends. The present statistical analysis of NADS data was designed to answer the following questions with two different samples drawn from the survey, a married group and a young single group:

Figure 11.1
The Interactive Effects of Age and Sex on Weekly Alcohol Consumption



- To what extent are women's and men's drinking correlated with their reports of spousal drinking?

- To what extent do social, demographic and economic variables relate to drinking behavior among women and men?

- To what extent do psychological factors, such as health status, the presence of stress or the availability of social support relate to drinking among women and men?

- Do these factors have a greater or lesser effect among younger versus older women and men?

Data Analysis[1]

Predictors of Use

The statistical analysis of the data employed multiple regression techniques with multistage direct entry hierarchic regression analyses (Tabachnick & Fidell, 1989).

Multiple regression techniques allow the investigation of the extent to which several independent variables influence an outcome or dependent variable. The statistical tool produces a regression equation, which predicts the behavior of the dependent variable. The question that is being asked determines the order of entry of the independent variables. When several steps are used, the complex interrelationships among variables may be revealed. The hierarchy or sequence in which independent variables are entered into the model is important.

In all cases, the dependent variable, drinking behavior, was measured in drinks per week. Separate multiple regression analyses for men and women were used to test all the main and some of the interactive effects of these variables on number of drinks per week. Because this type of analysis requires that the dependent variable be normally distributed, we transformed the alcohol use variable into its logarithm ($\log^{10}$) for these analyses, but for the purposes of communicating the results, descriptive statistics are given in terms of the original untransformed variables.

About 58 per cent of the NADS weighted sample is married or cohabiting. Because spousal/partner drinking is a predictor of the respondent's own drinking, the married sample was analyzed separately. In addition, because some members of the married/cohabiting sample are very young, and because the factors determining alcohol use may differ in the young, the analyses on the married sample were restricted to a sample aged 25 and over. Separate analyses were done for the younger sample. The married sample was made up of 2,339 women and 2,509 men, and the young singles of 849 women and 964 men.

Results

Married Women and Men

Regression analysis is a statistical method that allows for the explanation of a certain percentage of variability, or variance, in a dependent variable which, in this case, is married women's drinking. In this study, spousal drinking was entered as a control variable into the first stage of a multiple regression analysis. In the second stage, the demographic variables of age, education, work status (categorized as working or not, and entered as a dummy variable into the statistical analysis) and family income were added. In the third stage, the stress, social support and health ratings were entered. In the final stage, the interaction between age and each of the variables at the second and third stages, as well as the interactions among stress, social support and health, were entered. Finally, a reduced regression was produced in which any interaction that was not significant in either of the initial female or male regressions was eliminated.

The regression analysis on married women's drinking indicated that 23 per cent of the variance was accounted for by spousal drinking ($F(1, 2337)= 699.8, p<.001$). The addition of the demographic variables in the second stage of the regression analysis significantly increased – by 3.64 per cent – the percentage of the variance in married women's drinking that could be explained ($F=28.91, p<.001$), with education ($t=4.77, p<.001$), work status ($t=5.67, p<.001$), and income ($t=5.20, p<.001$), making significant independent contributions to the explained variance. Women who were more educated, were working and had higher family incomes reported more drinking than did other women. The addition of the third-stage variables again increased the explained variance significantly ($F=3.50, p<.015$), but this time by only 0.33 per cent. Health was the significant independent predictor ($t=-2.86, p<.01$): women who reported poorer health consumed less alcohol than did other women. The three interactions introduced in the final stage of the reduced regression explained an additional 0.77 per cent of the variance ($F=8.22, p<.001$), making the total $R^2=.278$. Table 11.1 gives the results of the final stage of the analysis. It should be noted that, with the introduction of the interactions, the main effects of age, stress and social support also became significant, suggesting that these main effects are being suppressed by the interactions among them.

Table 11.1
Predictors of Alcohol Consumption in Married Women and Men: Results of Final Stage of Reduced Regression Analyses

	Women (N = 2,339)				Men (N = 2,509)			
Predictors	r	Beta	s_r^2	t	r	Beta	s_r^2	t
Spousal drinking	.48	.45	.194	25.6***	.49	.48	.226	27.6***
Age	-.10	.21	.005	4.0***	-.11	-.11	.001	-2.0*
Education	.18	.08	.005	4.0***	.04	-.07	.003	-3.4***
Work status	.16	.11	.010	5.8***	.13	.05	.001	2.1**
Income	.19	.10	.008	5.0***	.15	.08	.005	4.0***
Stress	.08	.29	.006	4.3***	.01	-.07	.001	-1.0
Social support	.00	.16	.002	2.3*	-.00	.20	.003	2.9**
Health	-.11	-.10	.003	-2.7**	-.03	.13	.004	3.5***
Age x Stress	-.02	-.25	.004	-3.5***	-.07	.08	.000	1.1
Stress x Social support	.02	-.26	.004	-3.5***	.00	-.05	.000	-.7
Social support x health	-.05	.09	.001	1.4	-.04	-.20	.003	-3.4***
	R^2=0.278 $F_{(11, 2327)}$=81.3***				R^2=0.261 $F_{(11, 2497)}$=80.3***			

*p<.05 **p<.01 ***p<.001

The interaction between age and stress for married women is shown in Figure 11.2. There appears to be a difference in the lifetime drinking patterns of those women who reported more stress and those who reported minimal stress. Women under age 50 who rated their stress higher reported more alcohol consumption than those who rated their stress lower; for women over age 50, the pattern was reversed. Stress and social support have a complex effect on drinking among married women (Figure 11.3). Women who reported no stress in the last 12 months drank little alcohol, regardless of their level of social support. Those who reported moderate amounts of stress (not very or fairly stressful) showed increased drinking when they perceived a complete lack of social support. Women with very high stress ratings drank more when they had high levels of social support than when they lived under conditions of low social support.

Figure 11.2
The Interactive Effects of Age and Stress on the Alcohol Consumption of Married/Cohabiting Women Over 24 Years of Age

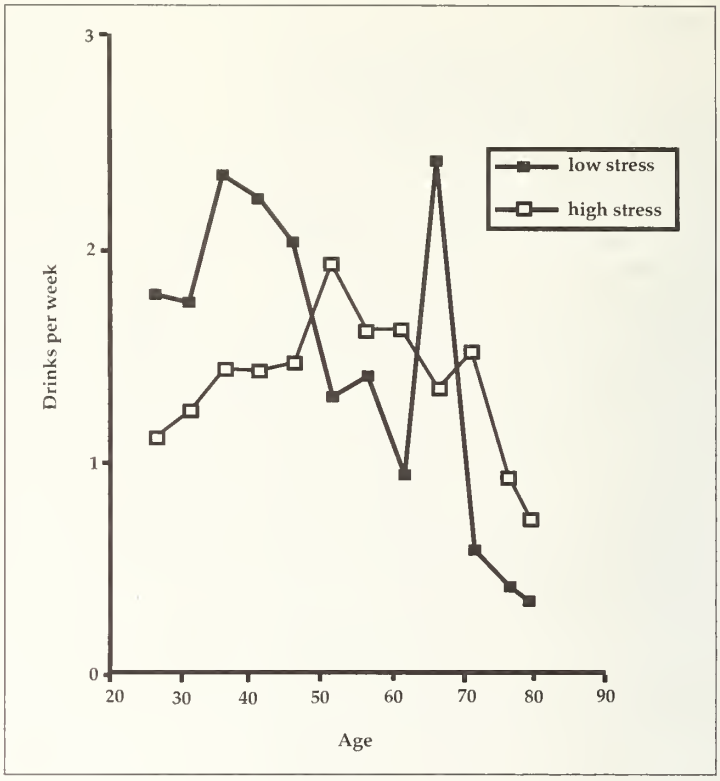


Figure 11.3
The Interactive Effects of Stress and Social Support on the Alcohol Consumption of Married/Cohabiting Women Over 24 Years of Age

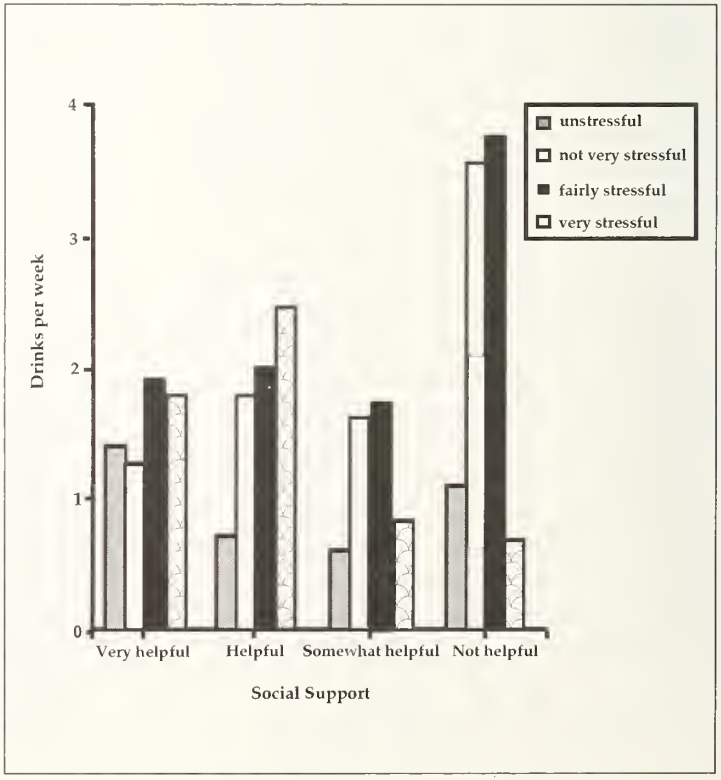
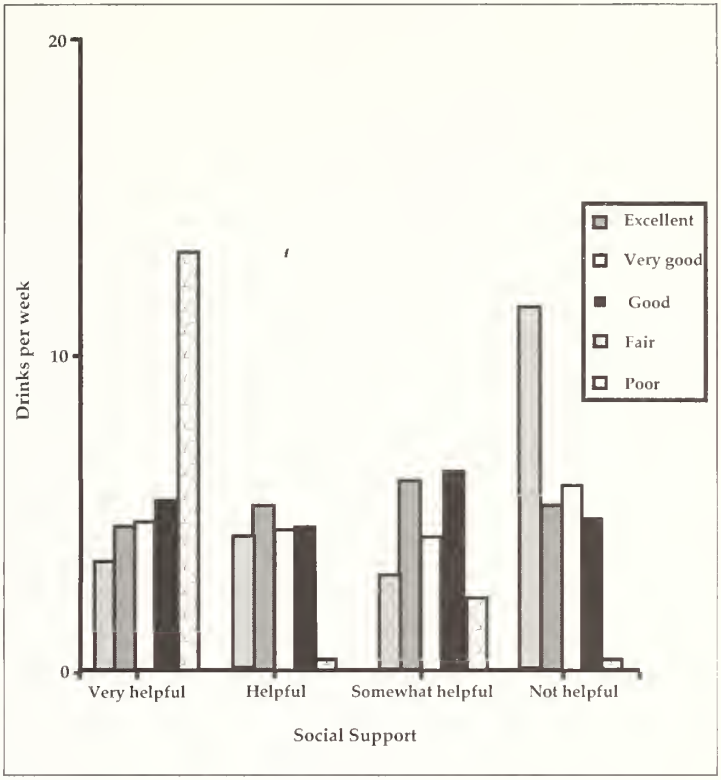


Figure 11.4
The Interactive Effects of Social Support and Health on the Alcohol Consumption of Married/Cohabiting Men Over 24 Years of Age



The regression analysis on married men's drinking indicated that 23.7 per cent of the variance was accounted for by spousal drinking ($F(1, 2507)=778.9$, $p<.001$). The demographic variables at stage two significantly increased by 1.9 per cent, the amount of variance that could be explained ($F=15.6$, $p<.001$), with age ($t=-2.36$, $p<.02$), education, ($t=-4.13$, $p<.001$), work status ($t=2.17$, $p<.03$) and income ($t=3.79$, $p<.001$) each making significant but small independent contributions to the regression equation. Men who were younger and less educated, and who were working and had higher incomes, reported more drinking than did other men. The addition of the variables examining the main effects of health, social support and stress did not significantly increase the explained variance in alcohol consumption. The addition of the interactions in the final stage of the reduced regression explained just a fractional 0.39 per cent of the variance ($F=4.41$, $p<.01$), bringing the total R^2 to .261. Table 11.1 gives the results of the final stage of the analysis. It should be noted that the interactions changed the findings for the main effects previously reported for social support and health, suggesting a possible suppresser effect due to the interaction between social support and health shown in Figure 11.4. Married men in poor health drank the most when their support was seen as very helpful. Those in excellent health consumed more alcohol when they lacked social support.

Young Women and Men Under 25

The statistical analyses of the drinking behavior of young women and men under age 25 differed from those of the married groups as follows: the demographics were entered as stage one, and marital status was added as a variable; student status

was substituted for work status; and income was dropped because of the large number of missing values. Some interactions with age were never entered, because certain cells or categories were impossible (e.g., 15-year-olds in college).

The regression analysis on young women's drinking indicated that the demographic variables together accounted for 7.8 per cent of the variance ($F(4, 844)=17.8$, $p<.001$), with education ($t=4.14$, $p<.001$), student status ($t=-4.24$, $p<.001$) and marital status ($t=-3.01$, $p<.001$) making significant independent contributions to the regression equation. Young women who were more educated, single and no longer students reported more drinking than did others. The addition of the second-stage variables increased the explained variance by 1.9 per cent ($F=5.90$, $p<.001$). Stress ($t=3.75$, $p<.001$) was the significant independent predictor; women who reported that their life was more stressful in the last 12 months reported greater alcohol consumption during the same period than did others.

The only interaction that remained in the final stage of the reduced regression was that between age and stress (Age x Stress). It did not significantly increase the amount of explained variance. Table 11.2 gives the results of the final stage of the analysis. It should be noted that the introduction of the interactions eliminated the significant main effects of stress.

The regression analysis on young men's drinking indicated that the demographic variables accounted for 18.3 per cent of the variance ($F(4, 859)=48.2$, $p<.001$), with more than double their predictive power in the equation for young women. Age was a significant variable for young men, who reported more drinking than did older men. (Age, on the other hand, was not a significant factor for young women.) Moreover, men with more education reported less drinking than did men with less education. This pattern was the exact opposite of the one found for the younger women. In addition, repeating the pattern found for young women, men who were single

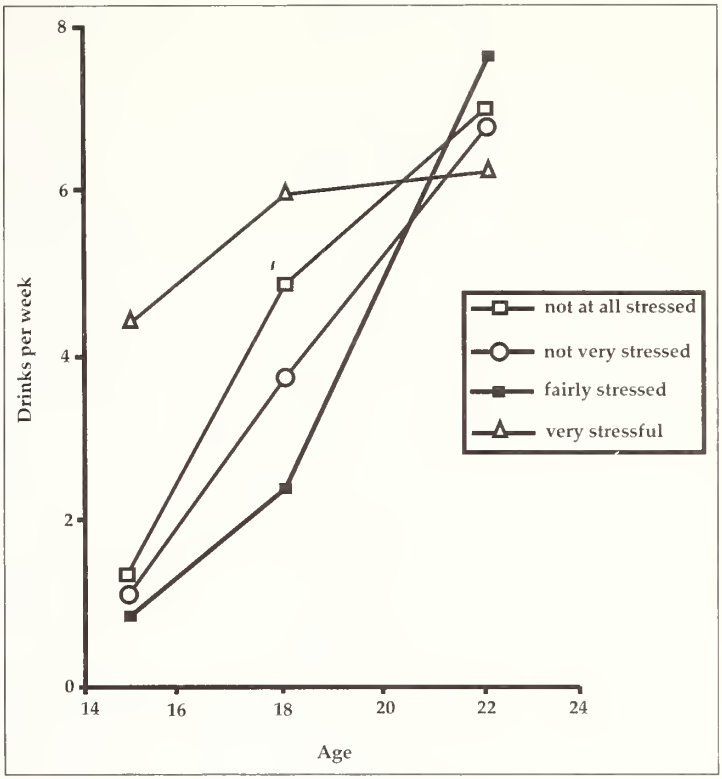
Table 11.2

Predictors of Alcohol Consumption in Young Single Women and Men: Results of Final Stage of Reduced Regression Analyses

	Women (N = 849)				Men (N = 864)			
Predictors	r	Beta	sr2	t	r	Beta	sr2	t
Age	.20	-.11	.001	-1.0	.38	.63	.036	6.2***
Education	.21	.16	.017	4.0***	.14	-.09	.005	-2.3*
Student status	-.18	-.19	.022	-4.5***	-.32	-.18	.021	-4.8***
Marital status	.02	-.11	.008	-2.8**	.04	-.11	.011	-3.4***
Stress	.16	-.23	.001	-.97	.10	.73	.010	3.3**
Social support	.05	.05	.002	1.4	.05	.05	.002	1.6
Health	.01	.02	.000	.5	.07	.03	.001	1.1
Age x Stress	.22	.40	.003	1.5	.21	-.74	.008	-3.0**
		$R^2=0.099$	$F_{(8, 840)}=11.6$ ***			$R^2=0.203$	$F_{(8, 855)}=27.1$***	

*p<.05 **p<.01 ***p<.001

Figure 11.5
The Interactive Effects of Age and Stress on the Alcohol Consumption of Young Males Aged 15 to 24



and no longer students reported more drinking than did other men.

In the regression analysis on young men's drinking, the variables at stage two significantly increased the explained variance by 1.1 per cent (F=3.86, p<.001), with stress (t=2.40, p<.02) making a small independent contribution to the regression equation. Men who reported more stress also reported more drinking. The addition of the interaction between age and stress (Age x Stress) in the final stage of the reduced regression explained an additional 0.8 per cent of the variance (F=8.79, p<.003), bringing the total R^2 to 0.203. The interaction, shown in Figure 11.5, seems to be caused by teenagers and young adult males who described their lives as very stressful. Those under the age of 20 appear to drink more alcohol than men who rate their lives as less stressful.

Conclusion

Because of the large sample size involved in this national survey, very small effects become statistically significant even though they may be of little importance in understanding drinking behavior. It is therefore necessary to draw conclusions with caution, although many of the small effects are consistent with previous findings on alcohol use.

How well do the demographics considered here and the ratings of stress, social support and health account for alcohol use? About one-fifth of the variability appears predictable in men under age 25, but obviously, important variables have been missed for young women. Among more mature women and men in established relationships, a major predictor of levels of drinking is the alcohol

consumption of the significant other, and the drinking of both sexes can be predicted equally well.

One major difference between women and men involves the influence of education. A higher level of education is correlated with greater alcohol use among women, a relationship that has been reported previously (Cahalan et al., 1969; Wilsnack, Wilsnack & Klassen, 1984). On the other hand, a higher level of education is correlated with lower alcohol use among men. This difference between the drinking behaviors of women and men may be a consequence of the overall disparity between their levels of drinking: the acquiring of higher education may act as an "equalizer," making the drinking patterns of women and men more at par.

One additional issue that must be addressed is the validity of using a single question to assess the complex and perhaps multifaceted concepts of stress, social support and health. For example, it is impossible to say exactly how members of the national sample interpreted the question on rating their overall stress level. Did they take into account only major life events, minor hassles or levels of anxiety? The rating on the single question, however, suggests that stress does play a role in the drinking of married females over age 25 and of young male adults, but is of little consequence for younger females and married males over 25. Health appears to be of greater consequence to the drinking of older married men. However, the impact of stress on the drinking behavior of women and of level of health on the behavior of men is affected in a complex way through the relative impact of social support.

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Notes

1. For discussion of terms related to statistics and data analysis, see the Glossary.

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CHAPTER 12

Substance Abuse Prevention and Treatment for Women: A Review of the Scientific Literature

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Introduction

This chapter provides a review of the literature on substance abuse prevention and treatment for women. It begins by presenting a general conceptual model, or intellectual framework, within which the authors can describe substance abuse health promotion, prevention and treatment programs. This discussion includes a summary of the basic types of treatment and prevention programs that have been described in the literature. An analysis of the methodological issues involved in assessing treatment outcome is followed by a review of the literature from 1980 to 1990.[1] The chapter concludes with a summary of the authors' findings and their implications for research and program development designed to address women's substance-specific health promotion, prevention and treatment needs.

Conceptual Framework

A variety of conceptual models have been proposed for describing and classifying alcohol and drug problems, including those presented in the third revision of the Diagnostic and Statistical Manual (DSM III-R) (American Psychiatric Association [APA], 1987) and the ninth revision of the International Classification of Diseases (ICD-9) (World Health Organization [WHO], 1979). In most current models, alcohol and drug problems are viewed as multidimensional, with biological, psychological and social components.

Substance use is one of the key dimensions, or elements, of all conceptual models, and can be described in terms of the amount, pattern and frequency of use. Individual patterns of use can be placed

along a risk continuum from low to high, with increased risk of social, psychological and physical consequences being associated with increasing amounts and frequencies of use, and with use in high-risk situations (e.g., before driving).

Current conceptual models seldom address the differences between men and women in the natural history of their substance abuse or in their symptom presentation (Braiker, 1982). Nevertheless, distinct differences in patterns of substance use appear between genders: women are more frequently polydrug users, particularly users of legal mood-modifying drugs, while men are more frequently users of illicit drugs (Blume, 1980; Cooperstock, 1971). In addition, men drink more often and drink more per occasion than do women. Women are also more likely than men to use substances when they are alone, while men are more likely to use substances in social settings (Crawford & Ryder, 1986; Johnson, 1982; Orford & Keddie, 1985). Women with substance abuse problems experience more health and physiological concerns, and possess lower self-esteem and poorer self-concept, than do their male counterparts (Colton, 1980; Beckman, Day, Bardsley & Seeman, 1980). Such women more often come from drug-abusing and disorganized families (Haver, 1987a, 1987b; Midanik, 1983) and more frequently have an alcoholic spouse than do their male counterparts. They are also more frequently responsible for children (Beckman & Amaro, 1984). Women substance abusers tend to be employed outside the home less frequently than are male substance abusers (Ferrence & Whitehead, 1980) and often have fewer marketable skills.

It has been observed that, overall, women who abuse substances tend to be isolated from conventional sources of support (Tucker, 1979), have higher levels of depression and anxiety, and experience more problems with self-esteem than do male substance abusers (Beckman, 1978a, 1978b; Corrigan, 1980; Robbins, 1989; Wanberg & Horn, 1970). They also report more stress in their families of origin (Corrigan, 1980). Women substance abusers are more likely to have a concurrent psychiatric affective disorder than are their male counterparts, who are more likely to have a concurrent antisocial personality disorder (Robbins, 1989; Schuckit & Morrissey, 1976; Wanberg & Horn, 1970). Women have also been found to have a rate of psychiatric disorder equivalent to that observed among men; women, however, are more likely to experience anxiety and psychologically based sexual and bulimic disorders than are men (Ross, Glaser & Stiasny, 1988).

Another component of many current conceptual models is the dimension of alcohol and drug dependence. Dependence on substances exists along a continuum from mild to severe. Criteria for assessing dependence include the development of a preoccupation with the substance, tolerance, and withdrawal symptoms following cessation or reduction in the amount of the substance used. Women have been described as having "telescoped" drinking histories, with the emergence of problems, particularly physiological problems, occurring after fewer years of problem drinking than would be typical for male drinkers (Dahlgren & Myrhed, 1977; Lisansky, 1957). The latter finding has, however, recently been challenged in the literature (Duckert, 1987). Women are also more likely than men to relate the onset of problem drinking to life events, such as divorce or childbirth (Wilsnack & Cheloha, 1987). Recently, sexual victimization has emerged as an important causal factor for women's substance abuse (Rohsenow, Corbett &

Devine, 1988; Skorina & Kovach, 1986). The failure of current diagnostic systems to address these gender differences in the causes and symptoms of substance abuse and dependence may account for the low rates of identification of women with substance abuse problems by health professionals (Robinson, 1984). It may also hinder the development of effective prevention and treatment programs.

Describing Substance Abuse Treatment and Rehabilitation: Health Recovery Programs

One striking observation which has only recently been made (Vannicelli & Hamilton, 1984) is that the vast majority of substance abuse treatments and self-help programs were developed by men for men. Only recently has there been a recognition in the descriptive clinical literature that, because of differing social and cultural experiences, women may have different preferences and needs for substance abuse treatment and related additional programs (e.g., child care, transportation) (Beckman & Kocel, 1982; Amaro & Beckman, 1984; Beckman & Bardsley, 1986; Thom, 1984, 1986, 1987; Vannicelli, 1984a, 1984b, 1984c).

Treatment for alcohol and drug problems can be obtained in a variety of formal and informal settings and from a variety of people. Those sought out for help might include both family and friends; authority figures who do not specialize in treatment, such as clergy; and professional treatment specialists, such as doctors or counsellors.

Women with alcohol and drug problems may also treated in a variety of settings: a physician's office, a hospital (either general or psychiatric), an inpatient or outpatient clinic, a community-based residence (such as a detoxification facility, where the average length of stay is two to three days, or a medium-term or long-term care facility, where the length of stay can be weeks or months). Treatment can also be integrated into more general health care or social welfare service programs through various rehabilitation programs (Adrian, Ogborne & Rankin, 1987).

Early intervention or secondary prevention programs target individuals whose pattern of use presents moderate risk. Treatment or rehabilitative programs (also called tertiary prevention) target individuals who have experienced some negative social, psychological or physical consequences related to their substance use. Thus, treatment and rehabilitative programs target high-risk groups.

Treatment has recently been defined as

> *an organized set of assessment and therapeutic activities with the objective of assisting clients in the reduction or elimination of problematic use of alcohol and other drugs, and improving and/or maintaining functioning in one or more dimensions of health. (Ontario Ministry of Health, 1990)*

A wide array of therapeutic interventions have been developed to address alcohol and drug problems. These interventions can be distinguished on the basis of a number of characteristics, including setting (residential vs. outpatient), philosophy, theoretical model, type and staffing.

Psychotherapy includes a range of talk therapies in which the client meets with a counsellor, usually individually. Psychoanalytic psychotherapies are based on some form of Freudian theory. The premise underlying these therapies is that alcohol and drug problems stem from unresolved developmental conflicts that, once identified, can be resolved.

Other types of psychotherapy, based on humanistic or client-centred theoretical models, are usually more present-focused and use a practical problem-solving approach. These models are based on the belief that individuals have within themselves the resources to solve their problems. The role of the therapist is to assist in the process of self-discovery.

Behavior therapy and, more recently, cognitive-behavioral therapy are based on social learning models of addiction. These therapies help people identify the way in which drug use has helped them cope with problems of everyday living. They assist in the identification of alternative coping strategies to help the individual cut down or stop alcohol and drug use. Examples of cognitive and behavioral strategies (which are typically validated through scientific studies) include self-management training, cognitive restructuring, contingency management, social skills and stress management training (Miller & Hester, 1986).

Pharmacotherapy involves the prescribing of medication to treat an alcohol or drug problem. Examples include the prescribing of methadone in the treatment of opiate addiction and disulfiram in the treatment of alcohol dependence. Drugs are also sometimes used when another disorder, usually psychiatric, is thought to be primary. For example, a woman who is diagnosed as depressed may be prescribed an antidepressant to deal with her affective disorder.

Self-help groups are among the most widely known approaches to substance abuse and, more recently, to a wide variety of other problems. Most of these programs, including Narcotics Anonymous and Cocaine Anonymous, are based on the 12-step Alcoholics Anonymous (AA) program. More recently, self-help programs designed specifically to address women's needs have been developed; these include Women for Sobriety and New Women for Sobriety.

Marital and family therapies comprise a group of co-existing therapies that arise from family systems theory. These therapies acknowledge that substance abuse may stem from problems within the primary social unit, usually the family. Underpinning other theories is a belief in the importance of wider community social support networks. In summary, substance abuse treatment occurs in a wide variety of settings, by a broad range of individuals – some have professional or paraprofessional training and some have no professional training – using a variety of therapeutic techniques.

Evaluating Treatment Outcome: What Works for Women?

Methodological Considerations

Deciding whether or not a particular treatment is effective is an extremely complex task. Substance abusers vary dramatically at the beginning of treatment in their level of dependence and associated problems. Descriptions of treatment interventions are frequently vague, and implementation evaluation is seldom addressed. There is little agreement as to what treatment outcome objectives should include, and what constitutes success in terms of substance abuse treatment is hotly debated.

Evaluation of substance abuse treatment for women received little attention in the scientific literature until the last 10 years. Prior to that time, research efforts, which were designed to assess the relative strengths of various kinds of treatment settings and methods, seldom addressed gender issues. Several literature reviews of substance abuse treatment

programs for women have identified problems in research design and measurement, including undersampling of women; failure to adjust for attrition, the expected decrease in client numbers; failure to address the different rates of attrition found for male and for female clients; failure to provide clear descriptions of client characteristics or program content; and failure to provide an adequate range of outcome measures. Vannicelli (1984c) recently observed that studies in which the principal investigator is a woman are far more likely to describe and assess gender effects. The gender bias in research has severely limited the development of an adequate database on which to make decisions about women's treatment needs.

Results of the Literature Review

The literature on substance abuse treatment for women can be divided into two broad groupings. Literature produced by clinicians and based on clinical experience is descriptive and impressionistic. Scientific literature documents experimental and quasi-experimental designs or methods used to discover the truth or falsehood of specific hypotheses about various treatments for women.

There has been little impact of the clinical literature on the scientific literature. Thus, insufficient key studies have been done to allow a comparison between the impact of a particular program on men versus women, or to assess the differing impacts of innovative treatments with related ancillary services designed to serve the particular needs of women. The research design, or method, that has provided the clearest information regarding the worthiness of a given treatment involves the random assignment of clients to the treatment program and to control groups. This method rarely occurs in clinical settings. More often, comparison groups of subjects that are similar to those in the treatment group are used to assess the impact of treatment.

Reviews of the Literature

Four systematic scientific reviews of the literature on substance abuse treatment outcome for women appeared between 1977 and 1986. This review provides an update on those earlier papers, as well as an examination of papers appearing in the last five years. We found a total of 211 articles, published between 1987 and 1990, that related to the broad topics of prevention, intervention and treatment of women's substance abuse problems. The articles were assigned, according to their content and/or the type of scientific study they described, to one of the following six categories: (1) random assignment with a control group, (2) non-random assignment with a control/comparison group, (3) non-random assignment without a control group, (4) prevention, (5) descriptive studies and (6) literature reviews and theoretical papers.

The majority (42 per cent) of papers presented descriptive studies, followed by those that presented studies involving non-random assignment without a comparison group (26 per cent). Literature reviews and theoretical papers accounted for 22 per cent of the papers. Only two per cent of papers we reviewed presented studies involving random assignment with a control group. A further four per cent presented studies involving non-random assignment with a comparison group. From 1982 to 1989, only eight papers (four per cent) that appeared in the literature specifically addressed prevention programs for women.

Summary of Reviews to 1989

When researchers present the possible outcomes for clients undergoing a given treatment for substance use and abuse problems, the outcomes are often divided into three categories, defining three levels of change in substance use behavior patterns: no change, improvement (a reduction in use with a consequent reduction in problems or risk) and total abstinence. Reviews to date have found no evidence to support the widely held belief that female alcoholics undergoing treatment can expect poorer results than can their male counterparts. There is also little evidence to suggest that any particular type of treatment is better for women than another (Annis & Liban, 1980; Duckert, 1987; Vannicelli, 1984b, 1984c).

The failure of the present literature to identify differences between the outcomes of men and women, however, cannot lead to the conclusion that there are no differences in the treatment needs of men and women. The scientific studies simply have not been done to evaluate systematically the beliefs and hypotheses that are widely supported in the clinical literature. For example, women are believed to prefer female to male therapists; to prefer all-female to mixed male/female treatment groups; and to use programs that include child care, transportation, and parenting skills and sexual abuse counselling. No data are available, however, to assess the usefulness of treating women separately from men or the relative effectiveness of male versus female therapists. In the review that follows, we will first present the evidence from controlled studies. This will be followed by a discussion and analysis of the information derived from descriptive studies, as it relates to each of the hypotheses above.

Controlled Outcome Studies

Experimental approaches to examining the effectiveness of treatments for women with substance abuse problems have followed two main designs. One approach has been to assign clients randomly to different types or modalities of treatment and includes the use of a control group. The other approach follows a comparative treatment or quasi-experimental design, in which subjects are compared with themselves (i.e., before and after treatment) or with those in another matched comparison group. Generally, a problem for researchers seeking to examine the effectiveness of treatments for women is the lack of data on the few women who do enter treatment programs. As indicated above, a computer search revealed only seven studies in the past 10 years that specifically examined treatment effects for women using randomized trials (Table 12.1) and seven studies using non-random assignment or comparative treatments (Table 12.2). Only two of these studies were conducted in Canada, both by the same research group (Sanchez-Craig, Spivak & Davila, 1991; Sanchez-Craig, Leigh, Spivak & Lei, 1989).

Table 12.1

Women's Substance Abuse Treatment: Randomized Studies

Randomized Design	Sample	Intervention	Outcome	Reference
1. Smoking cessation	F=70 M=69	4 conditions: relapse prevention vs. absolute abstinence, self-help or groups.	No main program effect. Relapse prevention more effective for women.	Curry, Marlatt, Gordon & Baer (1988)
2. Smoking cessation	F=55 M=61	4 conditions: nicotine fading vs. satiation, lay vs. experienced facilitators.	No gender differences, no main effects for type of treatment or facilitator.	Lando (1987)
3. Smoking cessation	F=33	6 conditions: 4 with flotation chamber, with or without messages, 2 control groups.	Control groups reported greater smoking reduction.	Forgays (1987)
4. Reduction in heavy drinking	F=38 M=52	3 brief treatments: guidelines, manual, therapist based.	Women significantly better than men in manual and guidelines.	Sanchez-Craig, Leigh, Spivak & Lei (1989)
5. Reduction in heavy drinking	F=35 M=61	3 brief treatments: guidelines, manual, therapist based.	Women significantly better than men in manual and guidelines.	Sanchez-Craig, Spivak & Davila (1991)
6. Reduction in relapse to chronic alcohol abuse	F=70	4 conditions: behavioral treatment with strict surveillance and/or placebo injections vs. treatment alone.	No differences except more relapses with placebo injections.	Watzl, Rist, Olbrich & Cohen (1988)
7. Early-stage problem drinkers	F=200	Specialized clinic for women vs. regular service provision.	Clinic group showed fewer social and alcohol problems.	Dahlgren & Willander (1989)

Table 12.2

Women's Substance Abuse Treatment: Comparative Studies

Comparative Studies	Sample	Intervention	Outcome	Reference
1. Cost of mixed drug abuse	F=155	Emergency hospital registrants, given personalized nursing vs. no home visits.	Lower drug use, economic and social costs after personalized nursing.	Anderson (1986)
2. Reduction in reported chronic alcohol abuse	F=78	AA residential treatment vs. detox plus own treatment choice.	AA program appeared more effective.	Smith (1985)
3. Rehabilitation success in drug abuse	F=67 M=61	Therapeutic community clients compared for attributional style and self-esteem, matched with controls from similar SES and locale.	Few gender differences, women showed small positive relationship between self-esteem and rehabilitation.	Gutierres & Reich (1988)
4. Consequences of shutting off methadone maintenance	F=153 M=178	Effects of transfer to fee-for-service, immediate, delayed, or no transfer, matched with those not shut off.	Higher crime rates and social problems, especially for those who did not immediately transfer.	Anglin, Spekart, Booth & Ryan (1989)
5. Employee Assistance Program referrals for alcohol problems	12 agencies F employees	Training supervisors and orienting employees.	Significant increase in F employee referrals.	Cahill, Volicer & Neuburger (1982)
6. Young drug abusers, under 30 years	F=32 M=68	Sociodemographic study of drug abusers, matched with city census.	Females more integrated with non-abusing peers over time.	Holsten (1985)
7. Heavy drinkers under 50 years	F=92	Sociodemographic study, high-risk, low-risk mothers, childless women, matched with women on city register.	Heavy drinkers had more social problems than matched controls. High-risk mothers had more problems.	Hollstedt, Dahlgren & Rydberg (1983)

Randomized Trials

Three of the randomized trial studies evaluated the outcomes of treatment for clients wanting to quit smoking. Four evaluated the outcomes of treatment for clients wanting to reduce their intake of alcohol or to abstain from it. There appear to have been no randomized trials involving women with mixed substance abuse problems (Table 12.1).

The three studies involving smokers concentrated on determining which treatment types have the best chance of encouraging smokers either to reduce or to eliminate their tobacco use. In none of these studies was the main hypothesis concerned with the determination of differences between the sexes. The first study found that women were more likely than men to benefit from a relapse prevention (RP) program, which emphasized gradual acquisition of coping skills, compared with the relative benefits of a program that stressed the need for absolute abstinence (AA) (Curry, Marlatt, Gordon & Baer, 1988). Women proved significantly more likely to quit smoking in the RP program. Since women have been found to be less successful than men in their attempts to quit smoking, the authors propose that women may do better in programs that do not focus on dealing with the problems of physical addiction, but encourage the development of coping skills. A general conclusion of this study was that the AA format helped clients achieve initial abstinence, but the RP format provided clients with the coping skills needed to deal with later lapses.

In the second study, Lando (1987) found no gender differences between 55 female and 61 male participants. The study sought to compare the relative effectiveness of group treatment delivered by lay facilitators with that delivered by doctoral counselling students. This study showed that the most important element in determining treatment outcome appeared to be the individual's ability to choose his or her own cessation preparation technique – satiation (mass exposure) or nicotine fading (slow withdrawal), of which the latter appeared to be the more popular technique.

The third smoking cessation study (Forgays, 1987) employed 33 women who were assigned to six different groups balanced for age, self-rated health, and amount and duration of smoking. Four groups spent varying amounts of time in a flotation chamber. Half the groups listened to a brief taped message that was relayed into the chamber during flotation. Two control groups did not spend time in a flotation chamber but were regularly telephoned, with or without the taped message. Although all groups reported reducing the average total number of cigarettes smoked at 12-month follow-up, the two control groups reported greater smoking reduction. The taped messages did not add to the effects of the treatment. The results of this study, however, must be considered with some caution, because group size was small (between five and seven per group) and no mention was made as to how many participants were not smoking at the 12-month follow-up.

Two of the alcohol studies examined treatment outcomes for heavy drinkers, and one study examined the outcomes for a more chronic alcoholic sample. Sanchez-Craig, Leigh, Spivak and Lei (1989) found a superior outcome for women in a comparison of a number of brief treatments for heavy drinkers. In this study, 52 men and 38 women were randomly assigned to one of three treatments. These treatments were (1) Guidelines, in which three sessions of advice were given, based on a pamphlet outlining steps for

achieving abstinence or moderate drinking, (2) Manual, in which three sessions of instruction in the use of a self-help guide were given and (3) Therapist, in which six or more sessions of instruction were given, following the steps given in the self-help manual. Eighty per cent of the clients were located at three-month follow-up, and 71 per cent at six-month and 12-month follow-ups. Both men and women in all three treatment groups reported significantly reduced drinking at three months. This finding remained stable over the rest of the follow-up period. However, women who underwent both the Guidelines and the Manual treatment programs reported reducing their drinking significantly more than did the men who took part in those programs.

A second study involving the same three treatments revealed the same findings at three-month, six-month and 12-month follow-ups (Sanchez-Craig, Spivak & Davila, 1991). Some reasons proposed to account for the observed gender differences are that women may do better than men in self-help treatment programs owing to past practice (e.g., dieting); they may be more motivated to avoid the stigma attached to participating in other treatment programs; or their more numerous physical symptoms (e.g., sleep disturbances, gastrointestinal problems, hangovers, mood changes) may have provided them with stronger motivation for change. The same differences between the genders were not found in the Therapist program, a more traditional type of treatment.

A more chronic group of female alcoholics with a primary diagnosis of alcohol dependence was studied by Watzl, Rist, Olbrich and Cohen (1988). They were assigned to one of four treatments: (1) behavioral treatment with strict surveillance of alcohol intake, and with placebo injections given, which were supposed to help ease withdrawal symptoms, (2) behavioral treatment with strict surveillance, with no placebo injections, (3) behavioral treatment with placebo injections but with no surveillance and (4) the treatment program alone. Female alcoholics assigned to the third type of treatment (behavioral treatment with placebo injections but no surveillance) were more likely than others to relapse. The authors suggest that patients who received placebo injections may have developed fewer skills to cope with the desire for alcohol. In this study, 46 (65 per cent) of the women had relapsed at an 18-month follow-up. Relapse, however, is not defined in terms of number of drinks, and no drinking variables are reported to have been collected at assessment.

The fourth study (Dahlgren & Willander, 1989) examined the treatment outcomes of women with alcohol problems who went to an experimental clinic established for the purpose of early treatment. The clinic was one of those conducted at an alcohol treatment centre. Women who registered at the centre were assigned, according to odd or even birthdates, to the specialized clinic (n=100) or to the regular service provided by the treatment centre (n=100). Assessment data showed that both groups were relatively stable, with the majority employed and living with a male partner. At follow-up, the clinic group proved to be more successful on many variables, including less need for hospital care, fewer relapses experienced, increased work capacity, improved relationship with their children, and lower incidence of mortality. Social drinking without problems was reported by 42 per cent of the specialized clinic treatment group and 20 per cent of the regular treatment group at the end of the second-year follow-up.

Although these studies are few in

number, a common finding appears to be that women do well, compared with men, in treatments that offer training in self-management, develop coping and relapse prevention skills and address personal needs.

Comparative Studies

The comparative treatment studies, summarized in Table 12.2, were designed to answer questions regarding the needs of women in treatment. Most of these studies, however, have problems relating to reliability, low follow-up rates, short follow-up periods, or collection of descriptive information rather than treatment outcome data. Only the first two studies describe and evaluate the treatment program itself, and only women were selected to participate in both studies. Therefore, gender differences cannot be compared.

Andersen (1986) conducted a three-year exploratory field study of 155 (72 experimental, 83 control) drug-dependent women to determine whether personalized nursing (PN) in their homes would alleviate some of their drug-related problems (e.g., cost of drugs, drug-free days, perceived stress). All the women had come for health care at a large urban hospital emergency room. They had all refused referral to a traditional substance abuse program and had all undergone treatment at least once before. The majority were unemployed (90 per cent), single (84 per cent) and black (86 per cent). The women were randomly assigned to the experimental or control group, and data were collected at registration, at eight weeks and at six months into the program. The experimental group underwent up to eight weekly one-hour PN sessions in their own homes, and the control group did not participate in any such sessions. The PN group reported lower costs of using drugs and less perceived stress than the control group ($p<.10$). Those who were part of a network of drug-using friends reported lower heroin costs than those who used drugs alone; reports, however, must be considered with caution because the numbers in each comparison group were small ($n<10$). The study achieved low follow-up rates for the treatment group; no mention was made of what happened to the rest of the sample.

Smith (1985) compared the experiences of 43 women who underwent a residential AA-oriented treatment with those of 35 women who underwent treatment at a detoxification centre. The women were matched on demographic and alcohol consumption variables. Considerable differences were found in the drinking status of the two groups at follow-up, conducted between 12 and 24 months after discharge. As might be expected, those women who were part of the residential AA-oriented treatment group attended more meetings than did those women who were part of the detoxification centre program group. They were also, as might be expected, more likely to perceive alcoholism as a disease. Smith's discussion of the study leaves the impression that there may indeed have been better treatment outcomes for the women in the AA treatment group, but that the study cannot be considered an objective one. Data concerning the two groups were collected in different manners. Outcome information for the women who underwent the AA-oriented treatment was obtained through interviews conducted with a treatment program leader. No such connection existed between the treatment provider and outcome evaluator in the collection of outcome information for the women who underwent the detoxification program. It is also notable that 25 (71 per

cent) of the detoxification group women enrolled in at least one treatment program for alcohol dependence during the follow-up period.

The other studies listed in Table 12.2 have various objectives. For example, Gutierres and Reich (1988) sought an alternative to traditional methods of predicting rehabilitation success by examining the predictive power of attributional factors and self-esteem in drug abusers. More men than women report attributing their success to internal and stable experiences; more women than men report attributing their success to external influences and chance events. It was hypothesized that women's tendency to attribute their success to outside influences and fortuitous events interacted with their lack of self-esteem to affect negatively their chances for rehabilitation. In this study, however, there appeared to be no clear relationships with rehabilitation success, other than a marginally significant relationship (r=.29, p<.07) between increased self-esteem and rehabilitation success for females only.

Anglin, Speckart, Booth and Ryan (1989) examined the consequences and costs of service changes for participants undergoing methadone maintenance programs (MM). Men and women in the study were compared on many demographic variables, with comparison groups drawn from MM programs unaffected by policy changes. Interviews were conducted two and one-half years after public funding of the program was terminated. Females appear to have coped better with the changes than did males. Both males and females, however, experienced serious individual and social consequences by discontinuance of public services.

The next study in Table 12.2 addressed the need to increase referrals to employee assistance programs (EAPs), since the estimated incidence of problem drinking among employees (12 per cent female, 22 per cent male) was higher than the rate of referrals (1.3 per cent female, 1 per cent male). Cahill, Volicer and Neuburger (1982) provided six of the 12 agencies they studied with a supervisor training and employee orientation program. EAP referrals of women employees were monitored at all 12 agencies. The study revealed a significant increase in the rate of female employee referrals at the agencies that received the program, and a decrease in the incidence of prior disciplinary action taken against women employees. Male referral rate changes are not reported in this study.

The last two studies in Table 12.2, from Scandinavia, sought to determine the characteristics and needs of women taking part in drug and/or alcohol treatment programs, and the changes among these women. The nature of the program studied in each case is not described, and a control group is taken from a public register of non-drug-abusing peers. Therefore, the effects of treatment on the drug or alcohol abuse of study participants cannot be evaluated. Holsten (1985) compared the background and drug abuse of males and females. Between 1971 and 1974, 32 females and 68 males were admitted to a psychiatric hospital program for young drug abusers. They were all under 30 years of age and had abused illicit narcotics for at least the preceding six months. A control group (n=95) matched for age, sex, and area of residence was drawn from the city census rolls. There was no difference in background between men and women drug abusers upon admission, although more women than men differed significantly from their matched controls. This situation had reversed by the end of the follow-up period, at which point females were

more like their controls. They were reported to be more integrated with non-abusing friends and to have fewer alcohol- and drug-related problems. Men were more likely than women to be polarized in their behavior patterns and more likely to exhibit either heavy drug use and consequences or no drug use at all.

In the second study, Hollstedt, Dahlgren and Rydberg (1983) compared the experience of 92 women, all under age 50, attending an inpatient hospital clinic for alcohol problems, with a group of women, matched by birth date, drawn from the city register. The groups were compared with each other in terms of the number of contacts with various social welfare agencies and evidence of criminality. The development of alcoholism in the clinic group was assessed from hospital records of interviews conducted during the treatment period; the drinking habits of the controls were assessed from the various public registers. The patient group was subdivided into those who (1) were childless, (2) had borne children before developing alcohol problems (called low-risk mothers) and (3) had borne children after developing alcohol problems (called high-risk mothers). More of the clinic patients had come into contact with child welfare agencies, and more had children placed in care. High-risk mothers were younger than low-risk mothers upon admission to the clinic; they had more psychiatric problems, a greater number of drinking consequences and more advanced signs of alcoholism. More of the high-risk group were registered for social assistance.

Clinical Descriptive Studies

Our review found little evidence in the experimental literature to substantiate the claim that women have different needs from substance abuse treatment programs than men. There is, however, considerable indirect evidence from a variety of clinical and descriptive studies to substantiate this claim.

Service Utilization Patterns

It has been well documented that women are less likely to use community alcohol treatment facilities than men. This reluctance has been related to the greater stigma attached to a woman's self-identification of a substance abuse problem; to the greater resistance shown on the part of a woman's family and friends; and to the fact that a woman will experience more negative consequences related to treatment entry, including negative effects on her family, negative responses from her family, loneliness, lack of money, job loss, avoidance by friends and anger from her spouse (Beckman & Kocel, 1982; Beckman, 1984a, 1984b, 1984c; Beckman & Amaro, 1984). In addition, the hospital-based model of alcohol treatment is often not accessible to women, who frequently have dependent children. Finding adequate child care can be difficult and expensive, and may jeopardize custody. Employee assistance programs are also less likely to identify and refer women than men (Cahill, Volicer & Neuberger, 1982; Cahill, 1983). It is also well documented that women of high socioeconomic status prefer to receive help from medical and psychiatric services, rather than substance abuse treatment services (Mulford, 1977), while women of lower socioeconomic status are more likely to have exhausted informal social supports before they seek any professional services. This latter group of women is also typically coping with a large number of problems. It has been hypothesized that these barriers to treatment involvement can also be used

to understand premature termination of treatment by women.

When women do use substance abuse treatment services, they prefer programs that provide a range of related additional programs and services. Beckman and Kocel (1982) examined the utilization rates of 53 various substance abuse treatment programs and found that women tend to utilize services that hired more professionals, provided treatment for children and provided aftercare. Women also preferred outpatient to inpatient services. Schultz (1975) demonstrated that increasing consideration of women's rights and needs in a mixed-sex alcohol and drug rehabilitation centre increased the number of women in treatment from 13 to 33 per cent, and the number completing treatment from 35 to 59 per cent. Provision of child care services has been found to increase a program's utilization by women by 30 to 50 per cent (Naierman, Savage, Haskins, Lear, Chase, Marvell & Lamathe, 1979). Significant increases in utilization by female clients have been observed when special services (such as pregnancy testing; prenatal and postpartum care; prescription drug use counselling; legal, vocational, child and sexual abuse counselling; plus training in vocational skills, assertiveness and parenting skills) are provided along with support services (e.g., transportation and child care) (Marsh, 1982). Similarly, the inclusion of a special outreach component for women in an EAP increased the number of referrals for women (Cahill, Volicer & Neuberger, 1983).

Components of Treatment for Women

Duckert (1988) has noted that all-female programs tend to encourage participants to focus primarily on issues related to a feminist understanding of sex-role conflict and to areas of psychosocial functioning, including family life, social relationships and self-esteem. These programs, however, typically do not encourage participants to examine the assumed causal relationship between substance use and other aspects of life functioning. Although some evidence suggests that rational-emotive therapy, assertiveness training, sexuality groups and family therapy may be effective for women (Henderson & Anderson, 1982), evidence drawn from scientific studies is still slight.

There is considerable evidence that a relationship exists between sexual victimization, whether experienced during childhood or adulthood, and the later development of affective disorders, anxiety and substance abuse disorders in women. Some addictions programs report that as many as 70 per cent of their clientele have been sexually abused (Covington, 1982; Hindman, 1979; Rasmussen, 1984; Dembo, Dertke, Borders, Washburn & Schmeidler, 1988a; Dembo, Williams, Wish, Dertke, Berry, Getreu, Washburn & Schmeidler, 1988b; Ladwig & Anderson, 1989).

Harrison and Hoffman (1989) analyzed the substance use and sexual abuse histories of 444 girls admitted to adolescent chemical dependency treatment programs. They found that sexual abuse victims were significantly more likely to make regular use of stimulants, sedatives, tranquillizers and hallucinogens than were non-victims. Sexual abuse victims also began use at an earlier age and used a wider variety of drugs.

Groenveld and Shain (1989) examined the relationship between alcohol and drug use and abuse (sexual/physical) in a telephone survey of 2,099 randomly selected Ontario women. They found that women who had been sexually abused as children or adults were at least

twice as likely as non-abused women to use medication to help them calm down or to sleep. Women who reported physical abuse by their partners were 74 per cent more likely to use such medication than non-abused women.

Victimization would thus appear to be a major etiological or causal factor contributing to the development of substance abuse problems in women. Clearly, providers of substance abuse treatment for women must include in their initial assessment and treatment repertoire measures to identify and treat abuse survivors if they hope to meet the needs of their clientele.

Conclusion

This chapter's review of the scientific literature supports the conclusions made in the reviews of substance abuse treatment for women to date. There are few solidly established facts about outcomes in the treatment of female substance abusers. Traditionally, there has been a widespread belief that, because of their greater degree of pathology, women are more difficult to treat than men and consequently benefit less from treatment programs (Henderson & Anderson, 1982). The available data, however, suggest that treatment prognosis for women is at least comparable to that for men and, in the case of some treatments, is superior (e.g., self-help and relapse prevention programs).

The second widespread notion, that women need different types of treatment and separate facilities, has never been adequately investigated in a methodologically rigorous study. Nor have the needs of special groups (elderly, disabled, offenders) been systematically investigated. Although a detailed consideration of these subgroups of women is beyond the scope of this chapter, they do have special needs that should be identified and addressed by treatment providers. For example, Lightfoot and Lambert (1991) documented high rates (53 per cent) of drug-related problems among women jailed in federal correctional institutions in Canada. High rates of family distress, eating disorders and histories of sexual/physical abuse (86 per cent) were also identified in this population. Elderly women are known to be at high risk for using multiple drugs and are therefore at increased risk for a broad range of physical, psychological and social problems. Disabled women suffer stigmatization, low employment rates, and high rates of poverty, victimization and social isolation. Both these latter groups may therefore require outreach and resocialization programs (to encourage them to seek treatment and teach them how to function better in society) in addition to substance-specific treatment programs if intervention is to be effective.

Future studies of substance abuse treatment for women would need to address a number of gaps identified in this review of the literature. First, there is a need for improved communication between clinicians and theorists if the outcome for women in treatment is to be improved. Second, there is a need for more treatment studies that use the most scientifically valid method for analyzing clinical trial outcomes, that is, random assignment with a control group, or at least the next best method, matched comparison groups.

Also needed are more studies that look at treatment outcomes for women and that address gender issues in therapy, including the relative impacts of female versus male therapists and mixed versus same-gender treatment groups. It is also necessary to assess the

importance of providing ancillary services (e.g., child care and transportation) as well as related programming (e.g., parenting skills training and sexual abuse counselling). It has been noted that few studies take into account the overall context of women's lives in their efforts to encourage cessation or enhance the effect of treatment programs. There is a need for future studies that would consider the effects of stress; the degree of support available from the family or partner; family life and child care responsibilities; possible domestic violence; women's employment at wages that fall below the national average; and never-ending, unpaid household work. There is also a need for studies that would examine the larger issues of class, race, ethnicity and language and their relationships to substance abuse and treatments. Ultimately, the varying availability of treatment services for women in different regions of Canada and its effect on treatment outcomes for women need to be considered.

Knowledge about the prevention and treatment of substance abuse problems among women in 1995 was at a rudimentary stage. If society hopes to increase its understanding of women's alcohol problems – and, hence, its ability to prevent and treat them – there must be adequate policy and funding support for basic and applied research that specifically targets women.

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Notes

1. The result of this survey is the compilation of an *Inventory of Addictions Treatment Services for Women*, published as a separate manuscript by the Canadian Centre for Substance Abuse (Lightfoot, Adrian, Leigh & Thompson, 1993).

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CHAPTER 13

Women's Use of and Views on Substance Abuse Treatment

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Introduction

Although traditionally there has been a lack of information about women's treatment needs and preferences, the National Alcohol and Other Drugs Survey (NADS) has provided a rich base of descriptive information about Canadian women. The NADS was a national general population survey carried out through all the provinces of Canada. It consisted of a sample of approximately 12,000 persons, about half of whom were women. The survey provides information on incidence and prevalence of alcohol and drug use problems among women, as well as their perception of these problems in the family and in the community.

This chapter presents the survey's results as they relate to women's use of and views on substance abuse treatment programs and resources. The chapter also addresses the issues of women's substance use as a means of dealing with problems. Data elements were statistically analyzed to measure the nature and extent of women's substance abuse problems and to determine the populations at risk for developing them. Also described are the types of treatments and other social interventions that women use to deal with their own problems and when referring others for help. Finally, women's level of satisfaction with the available programs and resources is examined.

The following specific questions were addressed in the NADS survey and could be used to measure the population at risk, women's perceptions of substance abuse problems, the interventions used by women to deal with problems (including self-medication), service utilization and level of satisfaction:

- What types of alcohol and drug problems do women identify in themselves?
- What problems do they identify in their friends and family on an individual basis?
- What problems do they perceive to exist in their community?
- What types of treatment do women want (say they would use, recommend to their family or friends)?
- How effective do they think treatment services are?

Finally, we examine the extent of our knowledge of women's alcohol and drug treatment in Canada.

Survey Methodology

The data were analyzed using SPSSX software on the VAX 11/750 and 11/780 computers at the Addiction Research Foundation. Unless otherwise specified, the analysis is based on sample weighted data. The results differ only very slightly from values based on an analysis of the unweighted sample; percentages generally differ at the level of the decimal. The overall pattern between men and women, and between different classes of women, types of services and other values of variables, remains basically unchanged.

The survey's results are described briefly below, and the major findings for women are shown on the accompanying tables. Where results for women differed significantly from those for men, the difference is noted with an asterisk and the letters "L," for women's results that are lower or *less* than men's, and "M," for women's results that are higher or *more* than men's.

Results

Alcohol and Drug Problems Experienced by Women Due to Their Own Substance Abuse

Women reported fewer problems than did men with friendships, marriage, health, happiness, work and finances due to their own use of alcohol (Table 13.1). Health problems were the problems most often experienced by women (eight per cent), followed by problems with friendship (seven per cent) and happiness (six per cent).

Table 13.1

Women's Substance-Related Problems: Lifetime Prevalence of Personal Alcohol-Related Problems

	% of Women
Friendships or social life	0.4 L*
Physical health	8.5 L*
Outlook on life (happiness)	5.7 L*
Home life or marriage	3.8 L*
Work, studies or employment opportunities	1.7 L*
Financial position	3.0 L*

L means figure for women was *less* than for men.
M means figure for women was *more* than for men.

Problems Related to Others' Alcohol Use

As shown in Table 13.2, more than half the women surveyed said they had had a relative with a drinking problem. More than one-third had had a friend and one-fifth had had a co-worker with a problem. More women than men reported having problems over their lifetime with their spouse or partner (six per cent) as a result of the partner's drinking. One-fifth said they had had a friend with a drug problem, and one-sixth said they had had a family member or relative with a drug problem.

(For a discussion of women's victimization due to alcohol abuse, see Chapter 10.)

Table 13.2
Women's Perception of Substance-Related Problems within Their Personal Social Network

	Alcohol		Drugs (Illegal & Prescribed)
	Yes (% of Women)		Yes (% of Women)
Problems with:	Ever	Last Year	Ever
Spouse/partner	6.3M*	2.6	1.1
Family member or relative	50.7 M*	23.5	14.8
Friend	37.4 L*	19.9	19.5 L*
Co-worker	22.1 L*	10.0	7.4 L*

L means figure for women was *less* than for men.
M means figure for women was *more* than for men.

Women's Perception of Substance-Related Community Problems

Many women were concerned about both alcohol and drug problems in their community. As shown in Table 13.3, almost half the women were concerned about drinking and driving; more than one-third about illegal or criminal activity due to drugs or alcohol; almost 30 per cent about alcohol-related health problems; and similar percentages about public fights or family conflicts related to alcohol. Almost one-fifth were concerned about alcohol problems in the workplace. More than one-quarter were concerned about the misuse of prescription drugs.

In short, women reported few personal alcohol or drug problems resulting from their own substance use. They reported experiencing a relatively higher level of problems as a result of someone else's substance abuse, and an even higher proportion were concerned about alcohol and drug problems in their community. These results may be due partly to the social stigma that remains attached to the admission of alcohol and drug problems. In such a climate, it is much easier to acknowledge publicly problems that are physically or psychologically distant from one's self or one's family.

Dealing with Problems

Ways of dealing with substance-use problems vary, depending on the type of problem, on the women's relationship with the person experiencing the problem and on the women's characteristics.

Table 13.3
Women's Perception of Community Problems

	% of Women
Drinking and driving	48.8
Family conflicts related to alcohol use	30.4
Public fights or disturbances from alcohol use	28.5
Alcohol-related health problems	31.2
Problems in the workplace due to alcohol use	18.7 L*
Misuse of prescription drugs and OTC drugs	27.1 M
Illegal drug use or criminal activity due to alcohol or drugs	35.7 L*

L means figure for women was *less* than for men.
M means figure for women was *more* than for men.

Using Drugs to Deal with One's Own Problems

There is some evidence that women are using psychoactive drugs, whether legal or illegal, as a means of dealing with their problems.

Women who reported their health as being "excellent" or "very good" (Table 13.4) were far less likely than others to use psychoactive drugs, including tranquillizers such as Valium, diet pills or stimulants, antidepressants, codeine/Demerol/morphine, or sleeping pills in the past 30 days, or marijuana in the past 12 months. At the same time, women who reported their health to be "good," "fair" or "poor" were generally more likely than others to report using psychoactive drugs, such as tranquillizers, stimulants, antidepressants, narcotics and sleeping pills. In contrast, there were no such differences in the use of other substances, such as ASA, allergy medicine and cold remedies between persons of different health status: the use of these substances was similar to what would be expected in each health group, on the basis of the distribution of each health status in the population.

Similarly, women whose lives were "very stressful" to "fairly stressful" (Table 13.5) were more likely than others to use tranquillizers, narcotics and marijuana. Those whose lives were "not very stressful" and "unstressful" were less likely to use these drugs.

Women whose family members were "not helpful" (Table 13.6) or only "somewhat helpful" were more likely than others to use legal psychoactives, whereas those whose families were "very helpful" or "helpful" were less likely to use tranquillizers, stimulants, antidepressants or sleeping pills. No such differences were found for use of narcotics (codeine/Demerol/morphine) or painkillers such as ASA.

As can be seen in Table 13.7, three per cent of women had some contact with the police as a result of their own drug taking and 2.1 per cent as a result of drinking. These rates are low, in general, and are significantly lower than those reported by men.

Table 13.4
Women's Use of Specified Drugs by Health Status

Health Status / Drug	Excellent	Very Good	Good	Fair	Poor
ASA	0	0	0	0	0
Tranquillizers	–	–	+	+	+
Stimulants	–	–	+	+	0
Antidepressants	–	–	+	+	+
Codeine/Demerol /morphine	–	0	0	0	+
Allergy medicine	0	0	0	0	0
Cold remedy	0	0	0	0	0
Sleeping pills	–	–	0	+	+
Marijuana last 12 mo.	–	–	+	–	0

0 = as expected.
+ = more use than expected based on percentage distribution of this health status in the population.
– = less than expected.

Table 13.5

Women's Use of Specified Drugs by Stress Level

Stress Level Drug	Very Stressful	Fairly Stressful	Not Very Stressful	Unstressful
ASA	0	0	0	0
Tranquillizers	+	0	–	–
Stimulants	–	+	–	0
Antidepressants	0	0	0	0
Codeine/Demerol /morphine	+	0	–	–
Allergy medicine	0	0	0	0
Sleeping pills	0	0	0	0
Marijuana last 12 months	+	+	–	–

0 = as expected.
+ = more use than expected based on % distribution of this health status in the population.
– = less than expected.

Table 13.6

Women's Use of Specified Drugs by Family Helpfulness

Family Helpfulness Drug	Very Helpful	Helpful	Somewhat Helpful	Not Helpful
ASA	0	0	0	0
Tranquillizers	—	—	+	+
Stimulants	—	+	+	0
Antidepressants	—	—	+	+
Codeine/Demerol /morphine	0	0	0	0
Sleeping pills	—	—	0	0

0 = as expected.
+ = more use than expected based on % distribution of this health status in the population.
– = less than expected.

Table 13.7

Women's Reaction to Substance-Related Problems

Response to Personal Substance Abuse Problems	Alcohol (% of Women)	Drugs (% of Women Drug Users)
Contact with police	2.1 L*	3.0 L*
Used alcohol/drug services	3.0 L*	2.5
Reaction to Problems Due to Someone Else's Substance Abuse	**Alcohol (% of Women)**	**Drugs (% of Women)**
Talked to someone about their drinking and drug use	14.1 L* (drinking at work)	N.A (friend using drugs)
Expressed concern to a friend or relative about their use of prescription drugs	N.A	25.2 L
Suggested to a friend that they stop using drugs	N.A	30.7 M*
Drove or arranged for transportation to take someone home from a party because you thought they had too much to drink	52.1 L*	N.A
Ever had contact with the police	8.3 L* (drunk driving)	2.3 L (using drugs)
Avoided the person	34.2 M*	24.0
Gave advice	58.5	62.4
Suggested they seek professional help or helped them to get assistance	48.3 M*	46.5

$p<.05$

L means figure for women was *less* than for men.

M means figure for women was *more* than for men.

Use of Specialized Substance Abuse Services

Women's rate of use of services for persons concerned about drugs or drinking was low, and lower than the rate of men's use (Table 13.8). Three per cent of all women in Canada – 204,000 women – reported using services for treating alcohol-related problems, and 2.5 per cent of women who used drugs – 50,000 women – reported using services for treating drug-related problems. The rate of use of specialized services for alcohol problems is in line with the proportion of women who acknowledge having problems with alcohol (i.e., between two per cent to eight per cent, depending on the nature of the problem). No comparable information is available about the proportion of women who acknowledge experiencing a problem with drugs.

Table 13.8
Substance Abuse Services Used or Suggested by Women

	% of Women
Used services for:	
Alcohol problems	3.0
Drug problems	2.5
Referred others to services for:	
Alcohol problems	48.0
Drug problems	46.0

Use of Alcohol Treatment Services

Women with drinking problems were more likely than others to use alcohol treatment services if they were separated, divorced or widowed; had attended some university or teacher's college; had no more than elementary education; or fell into the "other education or training" category. They were also more likely to use alcohol treatment services if their household income was in the lower categories (under $10,000 or from $15,000 to $19,999); if their employment status was described as "other"; or if they worked predominantly in agriculture or other primary industries.

Use of Drug Services

Women with drug problems who use drug treatment services were more likely than others to be separated or divorced; to have some secondary education or some university or teacher's college training; to have low household incomes (under $10,000); to be looking for work; or to be employed in a non-agricultural primary industry, in construction, or in the business/personal services sector.

Dealing with Problems Due to Someone Else's Substance Abuse

As shown in Table 13.7, women have had more contact with the police due to other people's use of alcohol (eight per cent) than use of drugs (two per cent). For both types of problems, women reported less frequent contacts with the police than did men.

Most women have given advice to people with problems related to alcohol (58 per cent) or drugs (62 per cent), and almost half the women had suggested people seek professional help.

More than half the women had driven or arranged for transportation home from a party for someone who had drunk too much. Fewer women than men reported doing so, however, possibly because of their lesser likelihood of being in bars and other places or circumstances where drinking occurs.

Partly because of their lower rate of participation in the work world, fewer women than men have spoken to someone at work about their drinking. However, women were more likely than

men to avoid a person with an alcohol problem (over one-third of female respondents) or drug problem (one-quarter of female respondents).

Characteristics of Women Who Refer Others to Services

Women who suggested that others seek professional advice for drinking problems, or who helped others get assistance, were more likely to be separated or divorced; to have children under 15 living in their households; to have completed secondary school; to come from middle-income households ($20,000 to $29,999); to be looking for work; or to work in the construction, transportation, communication or agricultural sectors. They were least likely to come from the highest-income households ($60,000 or more); to be students; to fall in the "other" employment category; or to be working in the utilities or miscellaneous services sector.

The women who suggested that others seek professional help for drug problems, or who helped others get assistance, were more likely to be separated or divorced; to have children under 15 in the household; to have had some university or teacher's college training; to come from the lowest-income households (less than $5,000); to be retired; or to be working in construction, the non-agricultural primary industry sector, public administration or miscellaneous services.

Use of Substance Abuse Services by Self and Others

As shown in Table 13.9, a very small percentage (three percent) of women in the NADS survey responded that they used any services for their own problems. Among those women who had ever had a spouse, family member, friend or co-worker with an alcohol or drug problem, almost half had referred them to treatment services (48 per cent referred them for alcohol treatment and 46 per cent for drug treatment).

Out of 10 alcohol and drug treatment services listed in the NADS questionnaire, the leading choice was Alcoholics Anonymous or AA-type support groups. It was the leading choice among women seeking treatment for their own alcohol-related problems (two per cent of all women) and among women who referred others for their alcohol-related problems (77 per cent of women had a spouse, relative, friend or co-worker with a substance problem). AA was the second leading choice among women who referred others to treatment for drug-related problems (23 per cent). Their first choice was a doctor or nurse (Table 13.9). AA and a psychologist, psychiatrist or social worker were among the top three types of services used by women for their own alcohol-related problems, or for referring others for their alcohol- or drug-related problems. The category of doctor/nurse was among the top three types of services chosen by women who referred others for help. The category fell, however, to the bottom third of types of services chosen by women seeking help for their own alcohol-related problems.

Alcohol or drug addiction agencies were among the top three services reported to be chosen by women seeking help for their own alcohol problems. They were only mid-ranked among women who referred others for help.

Psychiatric hospitals, clergy and hospital emergency departments fell into the bottom third of types of treatment services chosen by women seeking help for their own problems or by women who referred others for help.

Table 13.9
Type of Substance Abuse Services Used or Suggested by Women for Use by Others

Types of Services	Used by Self % of Women	Referred Others % of Women Who Referred Others to Services	
	Alcohol	Alcohol	Drugs
Family member/friend	0.2	6.0	8.5 M
AA (Alcoholics Anonymous), Al-Anon, support group	2.5 L	76.7 M*	23.1 M
Psychologist, psychiatrist, social worker	0.3	10.4 M*	20.3 M*
Psychiatric hospital	0.04	1.7	2.0
Minister, priest, rabbi	0.04	4.5	2.4
Doctor, nurse	0.1	12.8	30.6 M*
Hospital, emergency department	0.1	2.4	5.7
Alcohol/drug addiction agency	0.3	6.5	16.6 L*
Detoxification centre, halfway house	0.2	10.0	16.7
Other	0.2	6.4	10.9

L means figures for women are *less* than for men.
M means figures for women are *more* than for men.

Women's Treatment Preferences

Regardless of their social or economic status, women were most likely to cite AA, Al-Anon or other support groups as the type of service they used to get help for their own drinking problems. In addition, separated or divorced women were more likely than other women to seek practically all types of services for their drinking problems. Women who were working were also more likely than other women to get help for their drinking problems.

Women with higher educational levels (e.g., with partial or completed university or teachers' training) were generally more likely than other women to seek a broader array of service types (including AA; family member or friend; psychologist, psychiatrist or social worker; psychiatric hospitals; clergy; doctor or nurse; or alcohol/drug addiction agency), whereas women with a lower (elementary) level of education were more restrictive in their choices. They were more likely than other women to report seeking help from a detoxification centre/halfway house, or from an alcohol/drug agency.

High-income women were less likely to choose assistance for their drinking from AA or a psychologist, psychiatrist or social worker.

Characteristics of Women Related to their Referral Recommendations

Separated or divorced women were more likely than other women to refer others for help for alcohol problems.

Women with a higher (university) level of education seemed more aware of the diversity of treatments available and were more likely than other women to refer others to a wide array of services.

Referring Others for Drug Problems

In general, women are most likely to refer others for help with drug problems to a doctor or nurse, which is the type of service most likely to be selected by the widowed and least likely to be selected by separated or divorced women. The separated or divorced refer people with drug problems to the widest choice of treatment types: they are more likely than other women to refer others to support groups (AA, Al-Anon, Narcotics Anonymous, etc.); a psychologist, psychiatrist or social worker; an addiction agency; a detoxification centre or halfway house; or clergy.

In general, whether for themselves or for those they referred to help, detoxification centres/halfway houses, addictions agencies and hospital emergency departments are more likely to be the first choice for women who are of moderate means, who have a lower level of education, and who are working or looking for work.

Satisfaction with Substance Abuse Services

As shown in Table 13.10, self-help programs, such as AA, were seen to be particularly effective by women, more so than by men: nearly 60 per cent of the women said they were "very effective." Almost half felt that emergency telephone services were "very effective," and the other half thought them to be "effective" only. Community prevention and treatment by social workers or medical staff were seen as somewhat less satisfactory: about 60 per cent thought them to be "effective." These questions, however, do not allow researchers to distinguish between women who felt these services were effective for themselves personally, for other persons, or for society in general. Almost 90 per cent felt that alcohol or drug education and prevention programs, as well as treatment programs, should be increased.

Table 13.10
Women's Perceptions of the Need for and Effectiveness of Substance Abuse Interventions

Effectiveness of Programs	% of Women Very Effective	Moderately Effective	Not at All Effective
Self-help programs (e.g., AA)	59.3 M*	38.2 L	2.5
Emergency telephone services	48.3 M*	47.1	4.6
Community prevention efforts (workshops, information on alcohol and drugs)	33.7 M*	57.8	8.5
Treatment by professionals	29.8	59.3	10.9
Level of Program Need	**% of Women**		
	Increase	Decrease	Leave the Same
Alcohol or drug education and prevention programs	88.8	1.0	10.2 L
Treatment programs	86.6 M*	0.7	12.7 L*

L means figures for women are *less* than for men.
M means figures for women are *more* than for men.

Discussion

The NADS provides information on women's perceptions of what treatment is available; where and by whom they prefer to be treated; where they would want to send their family, friends or acquaintances for treatment; and their subjective perceptions of the effectiveness of treatment received from particular providers or in particular settings.

It might also be interesting to know what type of substance abuse treatment women actually receive; in which settings; for which disorders; for how long they are treated; what the resource implications are; and what the outcomes of the treatment are. Unfortunately, very little of this information is available from the NADS. Some of this information is available from Statistics Canada, including information regarding formal treatments, such as those provided to inpatients of general or psychiatric hospitals. Concerning treatment provided outside the hospital setting (e.g., in the doctor's office), no information is available. For community-based information, detailed statistical data are available only for Ontario (Rush & Ekdahl, 1987), concerning some 200 facilities that provide alcohol and/or drug treatment services.

Hospital-Based Treatment for Substance-Related Problems among Canadian Women

Statistics on inpatient cases treated in hospitals have been collected for many years in Canada. These data include information on all inpatients treated in all hospitals in Canada. They provide detailed statistical information on the medical diagnoses for which patients received treatment during their hospital stay. Because one patient may be treated several times during a year, it is necessary to speak of cases rather than patients or persons.

General-Hospital–Based Treatment for Alcohol-Related Problems among Canadian Women

According to Statistics Canada (undated), in 1987–88 there were in Canada 10,679 female cases treated as inpatients in general hospitals for alcohol-related diagnoses, consisting of alcoholic psychoses (1,411), alcohol dependence syndrome (3,986), non-dependent abuse of alcohol (1,153), alcoholic neuropathy (15), alcoholic cardiomyopathy (18), alcoholic pellagra (2), suspected damage to the fetus from maternal alcohol addiction, listeriosis and toxoplasmosis (11), fetus or newborn affected by noxious condition in mother (due to alcohol) transmitted via placenta or breast milk (13), alcoholic gastritis (574), chronic liver disease and cirrhosis (3,389), toxic effects of alcohol (376) and excessive blood level of alcohol (1).

Relative to the total number of cases treated for these disorders, which include both men and women, women accounted for a minority of cases – 20 per cent to 30 per cent, in general, depending on the diagnosis.

General-Hospital–Based Treatment for Drug-Related Problems among Canadian Women

In 1987–88 in Canada there were a total of 8,581 female cases treated in general hospitals as inpatients for the diagnoses of drug psychoses (491), drug dependence (1,307), non-dependent abuse of drugs (632), drug dependence in the mother complicating pregnancy (118), suspected damage to the fetus from drugs (7), drug withdrawal syndrome in the newborn (48) and poisoning by narcotic analgesics (665) by sedatives and hypnotics (1,334) and by psychotropics (3,979).

Out of the total of all cases treated in hospital for these conditions (including both male and female cases), female cases accounted for a minority of all cases (about one-third), with the exception of cases treated for poisonings by analgesics, antipyretics and antirheumatics, and poisonings by psychotropics, in which females predominated (Statistics Canada, undated).

Psychiatric-Hospital–Based Treatment for Substance Abuse Problems

According to the NADS survey, psychiatric hospitals were the least likely type of service to be used by women or to which women referred others for treatment.

Treatment for Alcohol Problems

According to Statistics Canada (1990), in 1987–88 there were in Canada 749 female cases treated in mental and psychiatric hospitals for the following alcohol-related diagnoses: alcoholic psychosis (64), alcohol dependence syndrome (587) and non-dependent abuse of alcohol (98).

Female cases represented approximately 20 per cent of the total caseload treated in mental and psychiatric hospitals for these diagnoses.

Treatment for Drug-Related Problems

In 1987–88 in Canada, there were 425 female cases treated in mental and psychiatric hospitals for the following drug-related diagnoses: drug psychoses (52), drug dependence (261) and non-dependent abuse of drugs (112).

Relative to all cases treated for these diagnoses, women represented about one-third.

Community-Based Treatment

Comprehensive national data on community-based treatment are not available. However, there are data available based on a survey (Rush & Ekdahl, 1987) of some 194 community-based treatment facilities in Ontario in 1985–86. Primarily these facilities were hospital affiliated, such as detoxification (19), residential (18) and non-residential (17) facilities, as well as community-based facilities such as assessment and referral centres (25), Addiction Research Foundation centres (4), residential (83) and non-residential facilities (25), and family programs (2). Of the clients treated in those facilities, 10,463 were women. Women represented approximately 30 per cent of the total caseload (including both men and women); women, however, were underrepresented in the detoxification facilities, constituting only 11 per cent of their caseload.

Ontario represents roughly 40 per cent of Canada's population. If the availability of treatment resources, the rate of alcohol-related and drug-related problems among women, and women's propensity to seek treatment were the same across the country, and the same as those patterns found in Ontario, then it would be possible to estimate that the number of women seeking community-based treatment across the country would be on the order of about 25,000.

What Is Not Known about Women and Substance Abuse Treatment

Despite the wealth of data in the NADS and the comprehensiveness of data on treatment in hospitals, there is no clear grasp of the relationship between the population at risk for developing alcohol- and drug-related problems and their likelihood of getting treatment.

About 70 per cent, or 7.4 million women, drink alcohol, while 2.4 per cent, or 215,000 women, say they drink daily. About 204,000 women say they have used services or help for their drinking, with most people favoring AA services.

About 1.8 million women reported that they had ever used illegal drugs, while 2.5 per cent of them, or 50,000 women, reported that they had used services for helping with drug-related problems.

Detailed information on treatment is limited to hospitals (including psychiatric hospitals, the type of service least likely to be used or suggested for people with alcohol or drug problems). There are an estimated 25,000 cases treated in general and psychiatric hospitals for alcohol and drug problems. Because one case may represent multiple admissions of the same patient, the actual number of persons treated is smaller. Another estimated 25,000 women are treated by community-based services. No information is available on persons treated through AA and other mutual-help resources, although they are by far the biggest providers of help to Canadian women, based on their responses to the NADS.

Although there are an estimated 254,000 women who say they have undergone alcohol or drug treatment in Canada, information exists on only 50,000 female cases, half of whom are treated in hospital, that is, in the most resource-intensive manner. These 50,000 cases (some of which may represent multiple admissions) correspond to, at most, 20 per cent of women treated.

It would be interesting to have additional information on the remaining 80 per cent of treatment services women claim to have used in order to determine what problems they treat, who they treat, how they treat, what their success rate is, and whether any of the techniques or approaches they use could usefully be incorporated throughout the treatment system.

Conclusion

The problems people encounter with alcohol and/or drug use and abuse can range widely in type, intensity and severity. Such problems, however, are probably more often perceived to be non-medical and may therefore be automatically directed toward non-medical resources such as self-help groups (about which there is no detailed treatment information). Treatments provided in hospitals, on the other hand, are more likely to concentrate on more severe cases than average, requiring more intensive medical care. Fear of unpleasant medical procedures may also keep some people away from hospitals.

Alcohol and Drug Use among Canadian Women

This analysis of the National Alcohol and Other Drugs Survey, as it relates to Canadian women, for the most part supports the picture of women's substance use and abuse provided by the literature review found in Chapter 12. Women report experiencing few alcohol or drug problems resulting from their own use, but higher numbers of problems resulting from others' use. A higher proportion of women is concerned about problems in their communities than that which reports experiencing problems resulting from personal use or the use of others. The data also suggest that when women do use drugs they use them to deal with problems. For example, women in good health were far less likely than those of other reported health statuses to have used psychoactive drugs in the past 30 days.

Use of other substances (e.g., ASA) was no greater or lesser than would be expected in each health group. Women whose lives were very stressful to fairly stressful were more likely than others to use tranquillizers, narcotics and marijuana, while those whose lives were not very stressful were unlikely to use them. Women whose family members were not helpful were more likely to use psychoactive drugs than were women whose families were supportive.

Most women who have used substance abuse treatment services, or who have suggested that others seek them, are most likely to use or suggest self-help groups and to express a high level of satisfaction with these services, which are the least costly to the public purse.

Women using treatment services were more likely to be separated or divorced. This finding is consistent with the data found in studies in the United States which indicate that women are more likely to use treatment services when they do not have other informal forms of support.

Many women are informal caregivers to their spouse, family, friends or co-workers with substance use problems, at the minimum giving people advice (58 per cent for alcohol problems and 62 per cent for drug problems). However, only three per cent of Canadian women report using services for the treatment of their own alcohol-related problems, and 2.5 per cent report using services for the treatment of their own drug-related problems. Women most often referred others to a doctor or nurse for problems with drugs (other than alcohol). Working women were more likely than were those not in the labor force to get help for drinking problems, especially from formal health care services (e.g., alcohol/drug agency).

Canadian women believe that alcohol and drug education and prevention programs, as well as treatment programs, should be increased. Women continue to experience lower levels of alcohol and drug problems than do men, but they are more likely to be affected by others' alcohol and drug use than are men.

In this chapter, we found that it is possible to account for only approximately 20 per cent of substance abuse treatment utilization by women. Half of this consists of inpatient treatment, while the other half consists of community-based treatment. It is not possible, however, to account for the other 80 per cent of the substance abuse treatment utilization by women. Some of this likely takes the form of interventions from mutual-aid organizations such as AA. There is clearly a need to identify better systems of data gathering and collection, in order to improve the understanding of women's use of treatment services. It was also clear from the inventory of treatment services for women in Canada (Lightfoot, Adrian, Leigh & Thompson, 1992) that services specifically designed for women in Canada are very limited. Programs that are funded have tremendous difficulty hanging on to their funding, even when formal evaluation supports the effectiveness of the program. Programs that have been specifically designed for women are often operated outside the traditional addiction or health care system, usually by social service agencies.

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CHAPTER 14

Canadian Women and Substance Use: Overview and Policy Implications

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Although there is a growing body of literature on women's use of alcohol and other drugs, relatively little has been written specifically about social policy responses to problems associated with women's substance use. There are large gaps in the research base required to develop such policy. Moreover, in practice, women's needs have not received the attention necessary to promote policies that would benefit them. By drawing upon issues raised earlier in this book, this chapter presents a framework for discussion about what can and should be done to reduce the harm associated with substance use by Canadian women.

Talking Policy

Some people think policy is remote from them, confined to cabinet rooms and boards of directors' tables. But most people talk policy a good deal in everyday life. Admittedly, much of this talk takes the form of criticizing existing policies, such as those that govern how social assistance programs function, what kinds of people are allowed to enter Canada as immigrants, or working conditions at the plant. Yet, when alternatives to the status quo enter into conversations, ordinary people are involved in policy analysis and advocacy, even though they may not call it that.

Policy discussions address what is being done about a problem and what might or should be done (Thurston & Bowhay, 1991). With regard to women and their use of psychoactive substances, concern is commonly focused on mental and physical health problems of users and their families. As we shall see in this chapter, the analysis must be taken beyond the

narrow confines of health policy, insofar as health and illness are influenced by the larger political, cultural and economic social context.

Policy may be defined as "any plan or course of action adopted by an organization, designed to influence and determine decisions, actions, and other matters" (Kolbe, 1988:390). It is apparent from this definition that concern about policy crosses many boundaries and jurisdictions and that at all levels of organizations, whether formal or informal, policy affects procedures. Attempts to change, monitor or study health policy can succeed if directed through all levels of government (federal, provincial, municipal) and through regulatory bodies. Change or study can also be focused on organizations, such as agencies or corporations involved in health promotion or service delivery, education, employee assistance and so on.

Approaches to studying policy can be grouped under two headings: analysis *of* policy and analysis *for* policy. The first classification includes studies of existing policies and policy processes, as well as research on how policies compare with one another. Analysis for policy encompasses gathering information for policy making, suggesting improvements in policy implementation, and advocating policy. Studying the impact of policies (outcome evaluation) can be used both in the analysis of, and analysis for, policy (Pederson, Edwards, Kelner, Marshall & Allison, 1988:11). Thus, the study of policy embraces a broad range of scholarly and political activities.

Historically, concerns about women and substance use have revolved around essentially moral issues: the supposed effects of alcohol and other drug use on women's "maternal instincts," their ability to care for their children and husbands, their sexuality and their "female purity" (see Chapters 1, 2 and 3). Remnants of this historical moralism remain today, for example, in the relatively more severe stigmatization of drunken behavior and drug dependence among women than among men (Beckman & Kocel, 1982). The modern policy focus has largely shifted from moral debates to issues of health, health promotion and prevention of substance-related problems as part of a larger movement in the field of health policy. However, health promotion is not free of moralism (Becker, 1986). In this chapter, we will show that policy regarding women is still influenced by concern over the morality of women.

In the past, health policy was considered to be solely related to the delivery of medical services, the protection of public health through sanitation, and the prevention of communicable diseases. Public health entered a new era with the rise of interest in health promotion, defined by the World Health Organization as the "process of enabling people to increase control over and to improve their health" (Becker, 1986:246). Since the 1974 publication of an influential government position paper (Lalonde, 1974), Canada has played a leading international role in advancing health promotion as an important aspect of the health care system.

A cornerstone of health promotion is "healthy public policy," a concept intended to recognize the array of factors, social and economic as well as medical, that contribute to well-being and to disease. As defined by Pederson et al. (1988:5), this policy is meant to be developed in collaboration with the constituencies it will affect, rather than being imposed from above. Thus, under this definition, healthy public policy incorporates certain values that are in alignment with the interests of the women's health movement (Ruzek, 1979): equity, partici-

pation, collective responsibility and sustaining health.

In keeping with the health promotion framework, health policy is now understood to be only one aspect of the larger social and cultural context within which it functions. This has led to the recognition of the need for an "overarching, perhaps integrating framework in which policies across all sectors are seen as affecting health" (Pederson et al., 1988:15). In this view, all aspects of social policy may have negative or positive consequences for health. Further, health issues are to be interpreted in the context of the larger social, economic and cultural environment. Women's substance use is a specific concern within the larger terrain of health policy. Therefore, a full understanding of the problems associated with women and substance use necessitates analysis of the status of women in Canada within a feminist theoretical framework.

The Feminist Framework

Policy assumes authorization to act (Reeves, Bergwall & Woodside, 1988:12). Therefore, discussions of authority and power are inherent in discussions of policy. Power is exercised by raising issues to the level of legitimacy, by selecting frameworks for the creation of policies and by controlling the implementation of policies (Pederson et al., 1988). The relative lack of power held by women is a central theme of feminist scholarship and policy analysis.

Historically, Canada's social institutions have been controlled by men – primarily, economically and culturally advantaged men. Thus, Canadian social policy has reflected their interests, their priorities and their vision of the proper social order. In recent decades, women have increasingly gained access to positions in the public and private realms where social policy is shaped. Concurrently, women's organizations, such as the Legal Education and Action Fund (Razack, 1991) and the National Action Committee on the Status of Women (Vickers, Rankin & Appelle, 1993), have been effective in communicating the concerns of women to policy-making bodies that previously would have neglected to consider them. The need for women's advocacy groups supports the argument that patriarchal social structure is still alive and well in Canada.

Within patriarchal social systems, women experience a multitude of difficulties ranging from facing stereotypical expectations of their abilities (both as girls and as women) to contending with the extreme exercise of male domination (as in spousal abuse and sexual assault). Men, too, suffer from gender-role stereotyping and the expectations imposed on them by patriarchal culture and ideology (MacKie, 1987). However, since men's experiences of oppression are qualitatively and quantitatively different from women's, their resulting problems will also be different and will give rise to gender-specific behaviors and symptoms. Therefore, assuming that substance use problems arise from constellations of cultural and biographical influences, as well as biological preconditions, it is unwise to assume that men's and women's experiences of them are the same.

Indeed, too often the authors of substance use literature inappropriately extrapolate from men's experiences in order to understand those of women. Curiously, this practice has co-existed with its opposite: the tendency to lapse into traditional gender stereotypes and blithely assume that women drug users differ from their male counterparts by being less self-directed, more dependent,

more bound to traditional values, or more prone to have whatever "feminine" characteristics seem suitable in the given case (Taylor, 1993). A feminist framework favors sound empirical research that seeks to gain an understanding of the daily realities faced by women substance users. It rejects the value of research that consists of an extrapolation of research conducted on men, or that is founded upon assumptions based upon traditional feminine roles.

"Medicine stands between biology and social policy" (Ehrenreich & English, 1973:5). This observation is of particular relevance to a discussion of women and substance use within a feminist framework. Physicians and psychiatrists have been major spokespersons on substance use problems. This is not surprising, considering their role in the diagnosis, care and treatment of alcohol and other drug users. However, they cannot necessarily be relied upon for their understanding of women in general, much less women with substance use problems. As Elston has observed:

> *A casual glance through most medical journals still suggests a male dominated professional world. Women, when they appear, are regarded as abnormal, deficient or troublesome members of the human race, despite, or because of, their special feminine characteristics.*
>
> *(1981:189)*

Furthermore, the medical approach to human problems (called the "medical model" by medical sociologists and others) tends toward a mechanistic vision of the human being, individualized and taken out of its social and cultural context. With regard to non-medical drug use problems, the medical model focuses on the actions of drugs on the mind and the body, with lesser regard for the sociocultural world in which that body lives. At the same time, it maintains that pharmaceutical substances, wisely prescribed, provide the answer to a wide range of human problems, including some substance use problems. Clearly, this presents a problem for healthy public policy, which encompasses a more sociological perspective on health and illness.

Male-dominated professions – whose participants tend both to both stereotype women and to view problems as arising from the individual rather than from the society – have been a source of concern for feminist scholars who study medicine and psychiatry (Ehrenreich & English, 1973; Penfold & Walker, 1983). The domination of men in certain professions is also perceived as an issue in the interdisciplinary study of substance use. For example, Brett and her associates (in press) examined the 17 major alcohol and other drug journals for the year 1990 for evidence of gender bias. When they compared their findings with those gathered from earlier examinations of this nature, they noted some improvement in research methodology. Their examinations revealed, however, that sex-biased sampling and interpretations in addictions journals were still evident.

With regard to the psychoactive drugs that women receive on prescription, Ettorre and Riska (1993:520) recently concluded that medical and sociological research is "... gender biased, gender blind and one-dimensional." This charge cannot be leveled at all current substance use research, and the methodology appears to be improving all the time. There is, however, no doubt that effective policy making with regard to women and substance use depends upon even further improvement. Substance use policy has traditionally been based upon male models. The focus of this chapter is to show

the contribution that a feminist framework can make in the development of women-centred policy initiatives.

The Problems Women Encounter with Substance Use

One of the legacies of history is the moralistic assumption that all drug use is necessarily detrimental to women. The authors hold that this assumption is false. At the same time, however, we recognize that some women encounter serious problems as a result of substance use. A sensible policy orientation, therefore, would not set the unrealistic goal of eradicating women's licit and illicit drug use. It would, instead, call for a search for ways to reduce the harm that can be associated with it.

This book identifies a number of problem areas with regard to alcohol, tobacco and illicit and prescription drugs. This chapter seeks to highlight these issues, as well as those raised in other sources on drug use by women. The authors will begin by examining the implications of the medicalization of women's problems (see Chapter 2). In so doing, they hope to situate subsequent discussion in the larger context of a feminist medical sociology. The chapter will then examine life course issues that are important to particular subpopulations of women, specifically the elderly (see Chapter 6) and women of childbearing age. It will then turn briefly to the problems of Canadian indigenous women (see Chapter 8). After a discussion addressing risk factors for drug-related harm, the chapter will address the problems experienced by women as a result of their substance use, bringing into focus prevention and treatment issues. It will conclude with a summary of the major issues it has raised and recommendations for research and policy initiatives.

The Medicalization of Women's Problems

In *A History of Women's Bodies*, Edward Shorter (1982) documents a depressing history of the terrible, chronic, debilitating conditions of women that resulted from untreatable gynecological problems, unwanted sexual intercourse and multiple pregnancies. Indeed, Shorter advances an intriguing theory on the rise of feminist thought at the end of the nineteenth century. He suggests that women could not begin to see themselves as equal to men until they could stop feeling that their bodies were a burden and could begin to gain a measure of control over their reproductive lives. According to this reading of history, women owe a great debt to medical science.

Unfortunately, women's encounters with the medical profession, although much improved over time with respect to their general health and life expectancy, have not always been positive (see Chapter 2). Women, despite being relatively heavy consumers of health care services, are reported to be intimidated by their doctors and misunderstood by a male-dominated profession that is neither responsive to their life situations nor sensitive to their needs.

Of particular concern in substance use literature are the relatively high rates of prescribed psychoactive drug use reported by women. Undoubtedly, there are Canadian women whose distress warrants the use of medication. However, research findings call into question physicians' prescribing practices and demand the consideration of alternative interventions (see Chapters 5 and 9). Andrews and Rootman (1990) report on the relationship between prescription drug use and a variety of factors that denote the living conditions of Canadian women. Some of these factors, such as marital status, income, education and age, are normally investigated in surveys. In their conclusions,

however, the authors suggest that attention should be paid to less easily measured variables such as loneliness. A recent study from New Brunswick (Davidson, Molloy, Somers & Bédard, 1994) suggests that the prescribing of drugs may be as much related to the characteristics of the physician as to the needs of the patient. The central question is whether psychoactive drugs are being prescribed for problems that might have other solutions.

Feminist scholars fear that this is indeed the case. For example, Ettorre characterizes prescription drug users as "passive consumers ... managed and manageable in an environment legitimated by male authority ..." (Ettorre, 1992:67). Her solution is for women to "recognize their potential for integrity, dignity, and self-respect as women" (p. 69) rather than to be forced into alienation from themselves by consuming prescribed drugs. Other feminists would suggest that this view emphasizes the passivity of women as unknowing and uncritical beings. Indeed, it could be argued that some women correctly assess their chances of changing their life situations as dismal, particularly if they try to act on their own. In their case, the consumption of pills or alcohol might be seen as a sensible choice for survival.

Women who work in the home have markedly higher rates of use of tranquillizers, antidepressants and sleeping pills than employed women (see Chapter 5). Does this disparity reflect attitudes of the medical profession – specifically, its assumption that the needs or vulnerabilities of "housewives" are not applicable to working women? Is it possible that some women who work in the home may constitute a special subgroup, one that is more "needy" and not up to the challenge of the workplace? The authors doubt that this is normally the case. They further doubt that most women who [illegible] attending psychological prob[illegible] She from obtaining pai[illegible] drugs h[illegible] so many of them ha[illegible] mor[illegible] the workforce in rec[illegible] by choice or econom[illegible]

Many Canac[illegible] notion that it is desira[illegible] remain at home for th[illegible] their children. This view is held even by young, university-educated women who can realistically look forward to satisfying and well-paying careers (Blackwell & McIsaac, 1990; Stewart, 1994). Thus, many full-time homemakers, encouraged by societal expectations, may in fact have *chosen* their role even though they have other qualifications. In summary, it is unlikely that homemakers are inherently more needful of psychoactive medications, although some of their doctors may perceive them to be so. More likely, their problems stem from the demands of their social roles as wives, mothers and housekeepers, and attest to the need for social action and change.

There is good epidemiological, anecdotal and clinical evidence (Brown & Harris, 1978; Harpwood, 1981; Penfold & Walker, 1983) of the potentially debilitating effects of social isolation, economic strain and other stresses on the psychological condition of women who work in the home. It is not enough, however, to urge physicians to exercise more restraint in their prescribing practices. It is also not enough simply to declare that the women who are currently receiving these drugs would benefit from increased self-esteem and respect. How can this be accomplished in a cultural context that does not appropriately reward "women's work," in which women are economically disadvantaged, and in which women and their accomplishments are undervalued and not appreciated (Canadian Mental Health Association [CMHA], 1987)?

the contribution of female users of alcohol and other drugs have historically been considered more pathological than their male counterparts because of a tendency of the medical and psychiatric professions to "place very narrow limits on appropriate sex role behaviors for men and women" (Clarke, 1995) (see Chapter 2). When women display typically "male" patterns of alcohol or illicit drug use, they are assumed to be "sick." When they complain of tension or anxiety in their personal lives, their doctors often prescribe pharmaceutical substances to help them cope. The medical management of women's distress is an important part of their substance use problem, and continuing efforts should be made to sensitize the profession to women's needs and circumstances. Nevertheless, the health promotion solution is most likely to be found in strategies to promote equality between the sexes and the well-being of all women. In the long run, it calls for the reexamination of our society, which treats more than half its population as second-class citizens and devalues their paid and unpaid labor.

The Aging Canadian Woman

Peele (1989:179) has remarked: "Simply arriving at old age is now often considered tantamount to having a psychological problem." He goes on to argue against the common wisdom that the elderly are a fragile group more vulnerable to alcohol and other drug problems. Contrary to popular belief, he suggests, "... age is an important ingredient in determining people's habits, in the large majority of cases leading to improved coping and self-contentment" (p. 181).

With the exception of the relatively high rates of prescription drug use reported by Canadian women over the age of 65, current data (see Chapter 6) would seem to support Peele's thesis. As a group, these women have relatively low rates of alcohol, tobacco and illicit drug use. However, on the basis of current data, it cannot be known whether the observed rates of alcohol and other drug use represent a decline because of the effects of maturation, or whether these use rates are simply typical of today's older generation. Will the women who are now in middle age report similar use rates two decades from now?

Alcohol and illicit drug use rates in older women are not alarming, but rates of prescription drug use are a source of concern. Overall rates of use, however, do not reveal the extent to which use per se results in problems. It is simply not known what proportion of older women are benefiting from these drugs, compared with what proportion are being put at risk for institutionalization, personal injury, loss of memory and so on. Research is badly needed on the consequences of prescribed drug use in this population.

Although overall use rates do not give us much information on the impact of medications on the health and well-being of older women, data analysis points to an issue that cannot be ignored by policy makers: the lower an older woman's income, the more likely she is to have been prescribed tranquillizers and sleeping pills. The survey data do not reveal precisely why these women received medications. However, tranquillizers and sleeping pills are apparently more frequently prescribed for older women who are less educated, financially distressed, in poorer health and under more stress than they are for their better-off counterparts.

As noted at the beginning of this chapter, healthy public policy is supposed to take into account the larger socioeco-

nomic context. Thus, it cannot ignore one of the most consistently reported observations of medical sociology: that health is positively related to social class. The better off you are, the healthier you are likely to be (Edginton, 1989). An older woman's financial position is a determining factor for predicting whether or not she is able to exercise a choice between accepting drugs (with potentially debilitating side effects) or seeking out healthy non-drug alternative therapies. Logically, therefore, healthy public policy for Canada's elderly women must address the disturbingly high rates of poverty found in this group (Statistics Canada, 1990).

Policy making for women substance users in this age group also needs to be informed by sound gerontological research. For example, research based on the National Alcohol and Other Drugs Survey (NADS) shows that women aged 65 to 69 reported higher rates of alcohol consumption, better general health and more social drinking with spouses, relatives and friends (see Chapter 6). (The wide definition of "heavier" drinking in the NADS – which includes the consumption of a single drink on four different days a week – is problematic.) Should this group be targeted for a health promotion campaign? The evidence suggests not. Some patterns of social drinking might well turn out to be an index of healthy adaptation for older women living in isolation and abject poverty. It would appear important, however, to learn more about drinking patterns in older women. Only well-conducted, multidisciplinary gerontological research will answer such questions.

Healthy Childbearing and Drug Use

One of the authors of this chapter recently spoke with a general practitioner who complained about the burden of attending the pregnant women in her caseload. She noted that in the early years of her practice, prenatal care was one of the most rewarding aspects of her work. Now, however, her telephone was ringing constantly, with patients worrying over the latest media coverage of a new risk to the fetus or wondering about cautionary advice they had received from friends or relatives. In the opinion of this physician, pregnancy had changed from being a joy to being a source of guilt and anxiety. This anecdote raises the issue of the potential harm that can be done by policies intended to promote health.

McCormack (1993) argues that women were not well served by the widespread acceptance of Fetal Alcohol Syndrome (FAS) as a danger to future generations and the publicity it received in the media. In her argument, McCormack outlines the recent social construction of pregnancy as a high-risk endeavor, "not to be left to chance or the folk knowledge passed on from mothers to daughters" (p. 15). The fact that pregnancy is no longer seen as a joyous rite of passage but a high-risk endeavor is reflected in the experiences of the family physician recounted above. In an ethical analysis, however, it is important to ask whether a policy of encouraging anxiety over light social drinking in large numbers of women is justified by evidence of increases in physically, mentally and socially healthy children.

Unfortunately, the vast research conducted on Fetal Alcohol Syndrome yields no satisfactory answer to this question. Incidence estimates vary widely, but have been conservatively rated at just over three cases in every 10,000 live births in non-aboriginal populations. This estimate is based on figures for the population of the United States, where the number is just under three cases for whites and

almost five for blacks (Abel & Sokol, 1991). Despite the apparently rare occurrence of FAS, pregnant women are routinely warned that there is "no safe level" of alcohol consumption, and advised that complete abstinence is the safest option (McCormack, 1993). Expectant mothers are not told whether alcohol-related risks can be expected to decline in the second and third trimesters, as is the case with other drugs. Indeed, the "no safe level" warning is extended to women who are simply thinking about pregnancy.

The legitimacy of concern over potential fetal damage as a result of maternal substance use cannot be denied, but perhaps it can be overplayed. Furthermore, there are important considerations that escape public discussion in the media and that are not communicated to women by their doctors. For example, although a significant proportion of pregnant women are prescribed a wide array of pharmaceutical substances (Ettorre, 1992), research on the effects of these drugs on the fetus has been less enthusiastically pursued than research on the effects of alcohol and illicit drugs. In a glance at the essential physicians' handbook, the *Compendium of Pharmaceuticals and Specialties* (Canadian Pharmaceutical Association [CPA] 1994), one will discover a version of the following statement numerous times: "The safe use of this drug during pregnancy has not been established."

As McCormack (1993) suggests, it is interesting that the political agenda encouraged the study of women's vices, rather than research on the biology of fetal development. This is another example of the continuing influence on policy of the historical image of women's fragile morality. Furthermore, the moral development of women of non-European heritage is called into question by this agenda. Why does society encourage the condemnation of North American indigenous women or African- and Hispanic-Americans in the United States for their substance use? Why does it not, instead, direct the focus upon the difficult circumstances under which these women commonly live and the possible effects of these conditions on the health of children?

Concern over pregnant women's substance use has also led to new threats to women under the law and by social service agencies. For example, McCormack (1993) reports a child abuse suit brought against a woman in Kenora, Ontario, after she gave birth while intoxicated. As her older child had already been diagnosed with FAS, the Children's Aid Society had been ready to act when the next baby was born. The court ruling, which confirmed the woman's "child abuse," cited her "neglect or refusal" to care for the child's health before it was born. One wonders why the Children's Aid Society took legal action against this woman rather than try to help her to understand the importance of good prenatal care. In light of this case, it would be interesting to know what services were available to help this mother, a woman with a history of alcohol-related offences, during her pregnancy.

A working group brought together by the Canadian Centre on Substance Abuse has produced a draft policy discussion paper on Fetal Alcohol Syndrome (Canadian Centre on Substance Abuse [CCSA], 1994). From a feminist perspective, this document can be applauded for recognizing that some of the diagnostic features of FAS may, in combination with alcohol consumption during pregnancy, result from other factors. Some of these factors are typically associated with poverty (inadequate nutrition, lack of prenatal care, other health problems); others, such as a woman's exposure to family violence and her use of other drugs, high-

light the need for a wide-ranging healthy public policy. The CCSA's draft policy discussion also acknowledges that parental guilt and anxiety may be an unintended adverse consequence of overly vigorous policy emphasis on the use of alcohol during pregnancy.

Women have argued for their right to control their own reproductive lives. They have also battled against the notion that they are simply passive vessels who, from time to time, may be carrying a being within them who has the rights of a person under law. Punitive policy measures against women who smoke tobacco, drink alcohol or take illicit drugs during pregnancy represent a philosophical backlash against the struggle women have waged for more than a century for control over their own bodies. A critical look at punitive policy measures, however, is not an endorsement of self-destructive behavior in pregnant women. Nevertheless, to call for punitive policies against them is to discourage women from seeking prenatal care (McCormack, 1993). It is also to discourage society from taking responsibility to help pregnant women, whose health may be threatened by poverty, malnutrition or family violence.

As noted above, women's drug use has historically been equated with their "failure" as women, wives and mothers. Even today, a woman's substance use problems may contribute to her losing custody of her children, and even having them placed in foster care. Yet, very little research has been done on the mothering abilities of substance users. Interestingly, the results of that research run contrary to the stereotypical conception. For example, Wilsnack and Wilsnack (1991) found very few female drinkers who thought that alcohol had interfered with their ability to maintain their households, and even fewer who reported that their children were having problems associated with their drinking. Of course, these findings are based on self-reports to surveys and may represent underreporting. Avril Taylor (1993), on the other hand, conducted participant observation studies on women who, in the public mind, might be thought to be poor mothers. Among the mothers that she studied who used intravenous drugs, most "... looked after and cared for their children perfectly adequately. With regard to motherhood, their attitudes, hopes, and expectations were traditional, and similar to those of non-drug using mothers" (p. 151).

In summary, although society expresses relatively little concern over male substance users' abilities to be good fathers, it appears to express an excessive concern over drug use by mothers and mothers-to-be. The anxiety generated in mothers and in the general public does not appear to be justified by the scientific evidence or by a realistic assessment of risk factors. Furthermore, the wisdom of encouraging the idea that fetal damage is a direct drug effect unmediated by other factors (such as social class and its correlates – nutrition, prenatal care, living conditions and so on) is questionable. Overreaction to the supposed damage that women substance users can inflict on their children, before and after birth, has led to the punishment and criminalization of women, rather than to the understanding of the sociocultural context of their medical and behavioral problems.

Health policy should support women to have healthy babies and raise healthy children. This support should include measures to promote not only general health promotion, but also flexible interventions for women who are experiencing substance-related problems or other adverse circumstances that threaten their well-being and that of their children.

It is illogical to expect women to participate in such interventions – to co-operate in treatment or to attend prenatal care sessions regularly – if by doing so they risk losing custody of their children or facing criminal charges.

Native Canadian Women and Substance Use

It is relatively easy to identify subpopulations of women substance users who might be singled out for special attention, but preparation of such a "shopping list" should be informed by a cost–benefit analysis of drug-related harm. It has been suggested that, on the basis of survey data, health prevention measures might be aimed at different ethnic and racial groups of women in Canada (see Chapter 7). A cost–benefit analysis, however, would undoubtedly focus on the magnitude and complexity of the problems of Canadian indigenous women (Statistics Canada, 1990).

The situation of Canadian indigenous women (see Chapter 8) presents a disturbing picture of elevated rates of morbidity and mortality, poverty, undereducation and unemployment. There also seems to be an unacceptable level of exposure to violence: spousal assault, child abuse and other forms of interpersonal violence. Rates of licit and illicit drug use are generally agreed to be higher than would be expected in the general population. No reliable estimates of rates of Fetal Alcohol Syndrome in this population are available (CCSA, 1994), but the totality of the adverse conditions described above suggest that the greatest risk for problems in newborns in Canada is likely to be found in this severely disadvantaged group.

The Conclusion of Chapter 8 specifies important information needed for policy development. It calls for the identification of successful programs or models for indigenous women, as well as the identification of the cultural and systemic issues associated with, and evolving from, their substance use and the interventions that have been designed for them. As noted previously, healthy public policy is intended to function within the wider context of people's lives and to be developed in collaboration with those people directly affected. Consistent with this, women from indigenous communities must be allowed and encouraged to take the lead in substance use policy making. Only they can fully comprehend the meaning and nature of the problems indigenous women encounter in living conditions on and off reserves.

Dealing with Women's Substance-Related Problems

This chapter has examined particular subpopulations of women whose substance use raises policy issues of concern. It turns now to the more general topic of the provision of services for women who need them, or who are otherwise attempting to reduce drug-related harm. The authors are hampered by the lack of some very basic information.

Tobacco presents perhaps the most straightforward problem. Rates of tobacco use among women are a source of concern, and smoking almost invariably involves some level of health risk. Because most former smokers, male and female, appear to have given up the habit without treatment (Peele, 1989), prevention and health promotion strategies might be a better investment than other interventions. Of particular concern are the numbers of teenage girls who are beginning to smoke (see Chapter 4).

Strategies to address this problem would benefit from sound empirical research into smoking initiation in young women.

As for most other drugs, society must face the problem of differentiating between women who will use them with little or no ill effect and those who may encounter problems. Even with a well-researched drug like alcohol, however,

> *... the findings from studies about why women drink and the factors that predispose them to alcohol abuse contain so much contradiction that distinguishing causes from effects is difficult.*
>
> *(Schmidt, Klee & Ames, 1990:181)*

For example, it has been noted that female alcohol drinkers in treatment suffer more guilt than men (Beckman & Kocel, 1982) and more feelings of depression and low self-esteem (Van Den Bergh, 1991). Women apparently are also less likely to come forward for alcohol treatment than men (Beckman & Kocel, 1982). The question then arises as to whether this subpopulation of drinkers selected themselves or were selected for treatment because of guilt, depression or low self-esteem. In other words, it is not possible to extrapolate data from treatment populations to the problem-drinking population, or to assume that features identified in women in treatment are necessarily determining factors in problem drinking. The same can be said for women in treatment for other kinds of drug use (Blackwell, 1993).

Longitudinal research from the United States suggests that depressive episodes and low self-esteem are risk factors for women's alcohol problems (Wilsnack & Wilsnack, 1991). As the medical model does not encourage researchers to enquire further than this observation, the problem of alcohol abuse is thus seen as a problem of individuals rather than of society. This view is mistaken. Alcohol abuse among women is a complex problem and cannot be dismissed as a simple expression of women's moods and self-perceptions.

> *For example, longitudinal data suggest that involvement in a nontraditional lifestyle ... may increase the chances that women will begin to drink in hazardous ways, as may low self-esteem, a history of childhood sexual abuse, and prior use of drugs other than alcohol. Risk factors for continuing problem drinking once begun may include sexual dysfunction, depression, and a lack of stable social roles (e.g., being unemployed, employed part time, or never married).*
>
> *(Wilsnack & Wilsnack, 1991:152)*

Even assuming that these findings would be duplicated in longitudinal research in Canada, what do they suggest? They certainly do not help to untangle the many possible causal connections among the various factors. The only factor that definitely can be considered an antecedent is childhood sexual abuse. The experience of childhood sexual abuse has been reported by over twice as many women problem drinkers (23 per cent) as non-problem drinkers (10 per cent) (Wilsnack & Wilsnack, 1991). Women with such histories have also been more likely to report experiencing episodes of depression and feelings of worthlessness, using drugs other than alcohol and becoming involved in relationships characterized by violence or conflict. Unemployment or underemployment may also underlie problems of mood and self-esteem, as might a variety of other stressful conditions that are not asked about in survey research.

Rates of illicit drug use among women are low, compared with rates of

alcohol, tobacco and prescription drug use. Nevertheless, there are significant risks associated with the use of illicit drugs: not only harm to health, but also harm resulting from their illegal status. Women with alcohol problems are stigmatized, but women who use illicit drugs face criminal prosecution, whether or not their use is causing harm.

Only a minority of women who use illicit drugs (as well as licit drugs) have serious problems as a result. Those who do, however, represent some of the most troubled women in Canada (just as they have been found to represent the most troubled women in societies elsewhere [Bjorling, 1989]). Here we encounter the "runaways" or "castaways" who have adopted the life of the urban streets (Webber, 1991), prostitutes and others involved in the sex trade, and women at risk for HIV infection because of needle use or because of unsafe sexual practices with men who inject drugs. Many of these women have histories of childhood and adult sexual abuse, and many live in oppressive and exploitative relationships with men. Finally, alcohol-related problems often accompany use of illicit drugs.

From a feminist policy perspective, it would seem wise to direct attempts to treat alcohol and other drug-related problems in women at the whole woman, taking into account her history and her life circumstances and not just her substance use. Account should be taken of the world in which a woman lives and the world to which she will return after treatment. This is not a new idea, as others have argued for comprehensive treatment services for women.

For example, Beckman and Kocel (1982) discuss a range of services that should be available to women being treated for alcohol-related problems, including assistance with transportation and child care, child counselling, prenatal care, counselling for incest victims and battered women, legal advice and employment counselling. These services need not be housed in one facility, as long as interagency links can be forged. This policy approach is significantly different from those that promote treatment programs that focus on self-esteem or skill enhancement in the individual, and interventions that deal exclusively with substance use.

It is important to consider the challenges of attracting women to services designed for them, and of encouraging them to continue participation once contact has been made. Evidently, spouses and families are less supportive of women entering treatment than they are of men (ARF, 1994). Moreover, it has been hypothesized that the personal costs of entering treatment are higher for women, who are more stigmatized than men and are more likely to have family responsibilities (Beckman & Kocel, 1982). Women are apparently more likely to be attracted to non-residential than to residential treatment, and they appear in higher numbers when agencies provide child care and aftercare services.

In another context, one of the authors (Blackwell, 1988) concluded:

> *The rigid models of the past ... have characterized drug-dependent persons as improbably self-indulgent or as unrealistically bereft of free will. ... It is little wonder that we have very few therapeutic success stories to tell. (p. 172)*

This was a plea for a broader and more social-scientific approach to problems among both male and female substance users. Nearly a decade later, the authors encounter the same issues raised in the literature on women and substance use: the individualization of their prob-

lems, rather than the consideration of the fabric of their lives.

Feminist scholars are uncomfortable with the medical model, the disease model (Blackwell, 1988) and the Alcoholics Anonymous or 12-step model (Ettorre, 1992; Kaminer, 1992). They argue against looking at women specifically as substance abusers; they argue for evaluating the larger sociopolitical context in which women in general and women who seek help for substance abuse live. There is no reason to believe that this same holistic strategy might not also work for men. Interestingly, it is also in accord with the "healthy public policy" approach currently thought to be the best for health promotion.

Recommendations for Research

In the past, the clinical experiences and observations of medical and addictions specialists have often been considered more valid than women's own experiences (Elston, 1981). Unfortunately, the latter have been largely ignored in the research literature.

A number of areas where research is badly needed were noted throughout this chapter. We need good ethnographic research on women's prescription psychoactive drug use to discover when it is appropriate and when alternative interventions could be recommended. gerontological research on women is also needed, particularly with reference to how alcohol and other substance use impairs or encourages successful transitions between life stages. More information is also needed on women's initiation to tobacco use, its continuation and cessation patterns. Are women really different from men in their use of tobacco, as Ettorre (1992) suggests?

More attention needs to be paid to the experiences of women who have overcome their difficulties on their own, without resorting to formal treatment services. In a social climate where it is believed that people with substance use problems "need help," it is perhaps not surprising that there is not a large body of research on spontaneous recovery. That which is available strongly supports Peele's (1989) conclusion: "If you have to bet your money, then bet that people will get better over time, usually on their own" (p. 176). In order to be better prepared to provide assistance to women who seek help, it is necessary to know how women extract themselves from problem situations.

It is far too easy for feminists and non-feminists alike to lapse into stereotypical thinking with regard to the condition of women as mothers and as workers. As noted earlier, the psychoactive prescription data suggest that some women who work in the home have problems with self-esteem and life satisfaction, yet no one would argue that these are problems for all women who have chosen traditional roles. In the absence of more in-depth research on modern motherhood, it is possible only to speculate about the meaning of the observed prescription drug use rates of women in the home. Similarly, there is controversy over whether the double burden of paid employment and family responsibilities increases or decreases the risk of substance-related problems. Lammers (1991) notes that the former position is not supported by empirical evidence in alcohol research. It may persist because it is a convenient way to argue against women's emancipation, suggesting that a return to the traditionally feminine role will solve women's alcohol problems. Survey data (Wilsnack & Wilsnack, 1991) suggest that multiple roles may actually increase women's mental and physical well-being. Further research is clearly needed in this regard.

Violence against women is a recurring theme in substance use literature, but its role in increasing women's problems is not well understood. As noted earlier, a history of childhood sexual abuse has been found to predate women's hazardous alcohol use. It has been reported that psychoactive drugs may be prescribed for women whose symptoms are a result of past or present experiences of violence and exploitation. The disturbing question is also raised as to whether some women use drugs to help them cope with abusive relationships. Clearly, more research is needed on the connections between women's substance use problems and their experiences of victimization.

A feminist perspective of substance use and related harm suggests a need for research that addresses the broad issues of women's mental and physical health in a society that devalues them as workers and as human beings. There is ample evidence that treated and untreated substance use problems recede when people feel that they have too much to lose. Research must be supported that will critically examine the barriers to women's full and satisfying participation in the social roles and institutions that give them a sense of self-worth, purpose and fulfilment.

Conclusion

Let us now summarize the policy recommendations that have emerged in this chapter:

- The research knowledge base regarding women and substance use should be founded upon studies explicitly focused on women. It should not be founded upon the extrapolation of data originating from research on men, nor upon assumptions based on traditional notions about femininity. Research programs should be designed that not only engage women as participants, but also ask research questions specifically applicable to women and their circumstances.

- Research on substance-related problems should focus not only on the psychopharmacology of substances or on the characteristics of women who develop problems, but also on the social and cultural context within which problems develop, escalate and may be resolved. Specifically, the authors call for analysis to be conducted with sensitivity to women-specific needs and problems, including their access to economic resources. The analysis must also be conducted with full understanding of society's attitudes toward women and their contributions, and of other issues of gender-based inequities.

- Programs should be developed to reduce the tendency to medicalize women's problems, and the medical profession should be encouraged to understand female patients within the larger social context of their lives. Cultural and socioeconomic issues should be examined in relation to the prescription of psychoactive drugs. The training and use of general health and social service providers in brief interventions with substance users may be particularly relevant for women, who are known to be relatively heavy consumers of health care but who are less easily attracted to substance-specific treatment programs.

- Harm-reduction approaches should be adopted to reduce the impact of problems related to substance use. Such approaches should include addressing the social and economic well-being of

women as a general strategy, as well as particular strategies centering around prenatal care, prevention of HIV infection and so on.

- Poverty should be addressed as a risk factor for all women, especially older women. Economic well-being can not only ameliorate the risks of substance use, but it can also be a precondition for selection of non-drug alternatives.

- Women who use substances should be supported in giving birth to and raising healthy children by interventions that respect the needs and rights of mothers, rather than by interventions that create unwarranted anxiety and guilt or that lead to adversarial situations.

- Indigenous women should be allowed to take the lead in developing policies that will best serve their families and communities.

- Tobacco policy should place a priority on research and prevention programs that address initiation to use, particularly by young women.

- Treatment for women who have substance-related problems should be directed at the whole woman, taking into account her history and her life circumstances, and not just her drug use. Agencies should be prepared to provide help to survivors of incest and child abuse, sexual assault and violence in the home, as well as to make available economic, legal and educational counselling for women who are experiencing barriers to needed changes in their lives.

- Provision of services for women should be flexible and take into consideration the kinds of life circumstances likely to prevent women's access to help, such as responsibilities for children, conditions imposed by partners or husbands, or economic hardship.

- Research on all aspects of Canadian women's mental and physical health and well-being, and their overall quality of life, should be encouraged.

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CHAPTER 15

The 1989 National Alcohol and Other Drugs Survey: Technical Notes

Marc Eliany

Introduction

The National Alcohol and Other Drugs Survey (NADS) was the first Canadian survey to focus on issues related to alcohol and other drugs. It was conducted in March, 1989 by Statistics Canada on behalf of Health and Welfare Canada (HWC). Other surveys, such as the 1978–79 Canada Health Promotion Survey (HPS), contained items on the use of alcohol and other drugs that were useful for analysis, but only to a limited extent. So, in consultations leading up to the formulation of Canada's Drug Strategy (CDS), researchers and practitioners expressed an overwhelming interest in the development of an information database that would permit in-depth analysis of issues related to alcohol and other drugs.

The data from the HPS provide a substantial basis for documenting the characteristics of alcohol use among Canadians, especially in conjunction with health and demographic variables. The HPS asked questions regarding knowledge, attitudes and beliefs about alcohol and other drug use. While there is considerable comparability between the HPS and the NADS, the differences are also striking. The questions on alcohol and other drug use in the HPS sought to provide basic consumption measures. Those in the NADS were designed to explore other factors rarely studied in international research, such as the settings where consumption takes place and the problems associated with alcohol and other drug consumption from the point of view of the user and of the victimized non-user. It also examined the actions taken to address the problems experienced. As may be seen from Table 15.1, the NADS covered a broader range of issues than did other relevant surveys.

Table 15.1

Tobacco, Alcohol and Other Selected Items by Survey, in Canada

	Canada Health Survey 78–79	Canada Fitness Survey 1981	Health Promotion Survey 1985	General Social Survey 1985	Drinking & Driving Survey 1988	National Alcohol & Other Drugs Survey 1989
Tobacco	yes	yes	yes	yes	no	yes
Alcohol consumption	yes	yes	yes	yes	yes	yes
Drugs	yes	no	yes	no	no	yes
Physical activity	yes	yes	yes	yes	no	yes
Self-rated health	yes	yes	yes	yes	no	yes
Mental health	yes	yes	yes	yes	no	no
Health problems	yes	no	no	yes	no	yes
Peer group practices	no	no	yes	yes	yes	yes
Social networks	no	no	yes	yes	no	yes

NADS Objectives

The objectives of the NADS were to assess and analyze Canadians' experience with alcohol and other drugs for the purpose of planning programs, evaluating existing policies and programs, and establishing a baseline for longitudinal analyses of patterns of alcohol and other drug use in Canada. Specifically, it sought to document

- national and regional patterns of alcohol and other drug consumption,
- reasons for using alcohol and other drugs,
- where and when people use alcohol and other drugs,
- the role played by family members and friends with regard to alcohol- and other drug-related behavior,
- consequences of consumption of alcohol and other drugs,

- actions taken in response to, or in anticipation of, these consequences and
- attitudes and beliefs held by Canadians on alcohol and other drug use, and their opinions on related policy issues.

The emphasis of the NADS is primarily socioepidemiological: survey questions focused not only on the experiences of the respondent but on the experiences of others as well. In answering the questions, each respondent acted as an informant reporting on the alcohol- and other drug-related behaviors of those within his or her social network, thereby increasing the survey's probability of detecting negative consequences of alcohol and drug consumption.

Population

The data for the NADS were collected through telephone interviews with 11,634 Canadians, of whom 6,343 were women. The survey interviewed people 15 years of age and older in all 10 provinces, but excluded residents of institutions, such as prisons and hospitals.

The exclusion of the Yukon and the Northwest Territories is estimated not to affect national averages significantly, although these averages may not be representative of consumption patterns in the Canadian North.

Since the NADS was conducted using random-digit dialling (RDD) – digit numbers on a telephone were selected at random and dialed in order to contact households at random – the two per cent of households without telephone service could not have been selected for inclusion in the sample. Although such households are known to differ from those of the general population in demographic characteristics, lifestyles and, in all likelihood, drug-related behavior, this exclusion is estimated not to bias NADS results (Catlin & Shields, 1988; Statistics Canada, 1989).

Survey Design

The respondents in this survey do not form a simple random sample of the target population. Instead, the survey had a complex, stratified (multilayered) design with different proportions of the population sampled in each stratum or layer.

In conducting the NADS, Statistics Canada used two RDD sampling methods: the Elimination of Non-working Banks method for Newfoundland, Nova Scotia, Ontario and Alberta, and the Waksberg method (Waksberg, 1978) for the other provinces (for a detailed description, see Statistics Canada, 1989). All households with telephones had an equal probability of being selected. Further, all members in each selected household were listed, from the oldest to the youngest, to select one member at random to respond to the survey questions and in order to prevent overrepresentation in the sample of persons most likely to be at home.

Sample Size

The sample size of 11,634 people was selected in order to produce national and provincial estimates. For this purpose, a sample allocation was made proportional to the square root of the provincial population. Whenever the sample allocation was significantly below 1,000, a supplement was added to fulfil the required quota.

Response Rate

Seventy-nine per cent of those people contacted responded to the interviews. This high response rate increases confidence in the accuracy of the NADS results. Typical reasons for non-response were: refusal of persons contacted to participate in the study, illness, injury, absence for the duration of the survey, language problems and no contact. In general, the 15- to 24-year-old age group tends to be underrepresented, and the 25- to 44-year-old age group tends to be overrepresented in the sample. The 45 and older age group is underrepresented in the sample, with the exception of females aged 65 and older, which group is overrepresented.

Collection and Processing of Data

Telephone interviewing was chosen as a low-cost way to collect reliable data and get a high response rate. Anonymity was guaranteed under *The Statistics Act* to increase the response rate (rate of people responding) and the likelihood that people would report the truth. The study did not allow one person to answer questions on behalf of someone else (proxy reporting), since many questions dealt with personal attitudes, beliefs and opinions. Nor could the interviewer accept the substitution of one respondent for another.

Interviews were conducted from Statistics Canada regional offices by a pool of experienced interviewers who received special training in concepts unique to the NADS. The work of the interviewers was monitored through periodic observation and reinterviewing of some respondents. As well, people who refused to take part in the survey were called back by a senior interviewer in the hope that they would reconsider and agree to participate.

All survey records were edited by Statistics Canada. Missing data were assigned a "not stated" code, except for cases requiring weighting. Variables such as sex and age were imputed randomly if missing.

Based on HWC specifications, derived variables and weights were added to the data.

HWC also prepared a code book that included variable codes and descriptions, standard variable definitions, derived complex variables and guidelines to facilitate analysis of the data.

An edited data tape was provided to HWC for additional test runs. Preliminary NADS data analysis indicated that findings were consistent with those found from other HWC surveys, i.e., the HPS 1985 and the Drinking and Driving Survey of 1988 (Eliany, Giesbrecht, Nelson, Wellman & Wortley, 1990). As a result, the NADS data tape was released for public use.

Guidelines for Analysis and Estimation

The complex design of the NADS – with its stratified multiple stages of selection of respondents in the sample, and unequal probability of a given respondent's being selected – affects the accuracy and kinds of estimations that can be made based upon it and of calculations of variances.

The unweighted sample, not being representative of the Canadian population at large, requires two types of correction: (1) sample records need to be weighted for the purpose of population projection and (2) the sample needs to be rescaled to its effective sample size (ESS) for the analysis of variance.

Basic Weights

The first type of correction assigns a weight to each NADS record as follows: A basic weight allows for the assumption that each telephone number reached (hit rate) is proportionally the same in the sample as it would be in the general population. It also corrects the data for possible biases resulting from household non-response, multiple telephones per household, selected person non-response and person-weight per household. Person-weight adjustments and provincial sex and age adjustments were made so that population totals in the survey would be consistent with census population projections at the time of the survey (Statistics Canada, 1989).

The weight attached to each record is used to produce estimates or conduct analyses that make the NADS sample representative of the Canadian population in March, 1989.

Effective Sample Size

The second type of correction required, rescaling, is appropriate when used in other techniques of statistical analysis, such as linear regression, logistic regression, estimation of rates and proportions and analysis of variance. Rescaling of NADS data is necessary to account for the sample design, and in order to produce a theoretical ESS for the purpose of calculating variances (although this is not necessary for the production of population estimates).

Validity of Self-Reported Data

In research on alcohol and other drugs, self-reported data are a primary source of information regarding consumption patterns. Given practical and methodological constraints, telephone surveys are one of the best forms of data collection. The reliability of self-reports on such negatively viewed behaviors as high alcohol consumption is of obvious concern to researchers.

An extensive literature review by Sobell and Sobell (1990) found that many research projects have determined that alcohol abusers' self-reports are reasonably accurate when interviews are conducted in clinical or research settings where respondents are sober and assured of confidentiality. A limitation of this literature review is that it focused heavily on individuals who were either actively involved in, or who had completed participation in, a treatment program. It is feasible that individuals who have gone through a treatment program would more readily admit to a problem with excessive alcohol consumption and would be more likely to understand the value of honest and accurate reporting. It is equally plausible that alcohol abusers in the general population would not be so forthcoming as those who have sought and been sent to a treatment program. Poikolainen (1985) found results that were reassuring regarding the accuracy of self-reports: he found that underreporting, while higher among heavy consumers than among light consumers, is still minimal the day following a drinking episode. Midanik (1982) conducted an extensive review of concerns associated with the validity of self-reported alcohol consumption and related problems. Midanik found that the accuracy of reports on others' behaviors and consequences was acceptable.

One method of validating responses on a provincial or national scale is to compare alcohol sales records (which are highly accurate) with the amount of alcohol that respondents report consuming. Most studies using sales data as a

check find that respondents' self-reports account for 40 to 60 per cent of alcohol sales. While there are various methodological explanations for this finding, none is particularly convincing, so caution must be exercised. It appears that most researchers act on the premise that, while self-reported consumption may not account for *all* alcohol sold, there are no subgroups that systematically underreport more than others. If one accepts this premise, it is then reasonable to conduct analyses assuming that survey results are proportionate for all segments of the population. While this approach may correctly place respondents on a continuum from abstainer to heavy drinker, it has limited value when the research objective is to establish threshold levels for high-risk behavior patterns.

Conclusion

A data collection instrument such as the NADS likely provides results that are reasonably accurate. While crude measures of the quantity and frequency of alcohol consumption tend to lead to considerable underreporting of consumption, the inclusion of multiple measures in the NADS produced results for comparative analysis with significantly higher estimates. The use of a diary approach, where respondents detail the amount of alcohol they consumed on each day of the previous week, tends to stimulate respondents' recollections and allows researchers to obtain more accurate reports (Redman, Sanson-Fischer, Wilkinson, Fahey & Gibberd, 1987). By probing for detailed information regarding quantity, frequency and setting of substance use, the NADS produced highly reliable recall and higher estimates of consumption.

It appears that such detailed questions about the frequency, quantity and setting of alcohol consumption produce estimates that are slightly higher than those from responses to questions about frequency and quantity of substance use. However, it is difficult to make a definitive statement because of the cumulative effect of multiple approximations. Any survey asking about a respondent's behavior during the previous week may inaccurately represent that respondent's usual behavior patterns because that week may have been atypical for this person. Nevertheless, distortions that may arise should not be very significant when the results of the entire sample are considered together at the aggregate level.

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(Note: Words that appear in boldface within definitions are also defined elsewhere in the Glossary.)

Alcoholic cardiomyopathy is a disease of the heart, found in some alcoholics.

Alcoholic neuropathy describes functional disturbances and/or pathological changes in the peripheral nervous system of some alcoholics.

Allopathic medicine considers the cause of disease to be due to an external agent, such as microbes, toxic substances, trauma, etc., so that successful treatment must be directed toward dealing with the external agent, for example, by the use of antibiotics. This approach contrasts with that of **homeopathic** medicine, which considers the cause of disease to be internal to the patient, whose functional processes are no longer in balance. Treatment is directed at interventions intended to allow body mechanisms and functional processes to regain their internal balance through indirect means, such as massage, mineral baths, etc. Modern western medicine is predominantly allopathic, although it has incorporated a number of purely homeopathic practices over the years.

Analysis of variance examines the pattern of distribution of values of a **variable**. A *2 x 2 analysis* examines the pattern of distribution for a particular variable as measured in two separate groups.

Anorexia is a lack or loss of appetite for food.

Anorexia nervosa is a mental disorder, occurring predominantly in females, which usually begins in adolescence. It is characterized by a refusal to maintain a normal minimal body weight.

An **antipyretic** is a drug that relieves or reduces fever. Some antipyretics also have an analgesic effect as painkillers.

An **anxiolytic** is an agent that reduces anxiety.

A **beta coefficient** is a measurement used in **regression analysis**.

A **bivariate analysis** examines the relationship of two **variables** in a statistical study.

Bulimia is a mental disorder, occurring predominantly in females, which usually begins in adolescence or early adulthood. It is characterized by episodes of binge eating that end with abdominal pain, sleep or self-induced vomiting. Bulimia differs from **anorexia nervosa** (in which bulimic episodes may also occur) in that there is no extreme weight loss.

Chi-square (X^2) is a statistical value or number obtained as a result of applying a test of significance, a chi-square test, to determine the degree to which the results of a statistical study are real, rather than a result of chance.

Cirrhosis is a disease of the liver often caused by alcohol consumption. It is frequently found in alcoholics.

A **coefficient** is a statistical value or number. It can be used to measure the relative importance of **variables** in relation to each other. For example, it can be used as a

multiplier to give a **weight** or relative importance to one predictor or explanatory variable in relation to others in a statistical analysis.

Cognitive restructuring is a strategy used in therapy that helps an individual identify the ways in which he or she learns things in order to change behavior.

Contingency management is a strategy used in therapy that helps a person identify and change his or her usual responses to various situations in order to change behavior.

A **correlation** is a statistical measure of association between two **variables** and indicates how likely they are to occur together.

d.f. stands for *degrees of freedom*. It is a numerical piece of information required for conducting many statistical tests of significance. The method used to obtain the degrees of freedom depends upon the test of significance for which it is necessary.

A **dimension** is a technical term used, for example, in factor analysis to define a type of category that can be established after analyzing measurements obtained for numerous **variables**, which, taken together, seem to have some common underlying feature or factor.

DRIE is a standard test used to measure the extent to which drinking behavior is determined by external influences.

Ethanol refers to the pure alcohol portion of an alcoholic beverage (e.g., beer contains about five per cent alcohol per volume; the rest of the beverage consists of water, flavorings, etc.).

F is a statistical description of variance.

An ***F*-test** is a statistical test of significance employed to determine the degree to which the results of a statistical study are real, rather than the result of chance alone.

Gastritis is an inflammation of the stomach. Alcoholic gastritis is found in some alcoholics.

Homeopathic (See description under **allopathic** medicine.)

A **hypnotic** is a drug that acts to induce sleep.

Listeriosis is an infection caused by the bacterium *Listeria monocytogenes*. In pregnant females, these bacteria can cause an infection of the uterus via the placenta, resulting in abortion, stillbirth and premature birth. Infections of a newborn baby acquired during birth can cause cardiorespiratory distress, diarrhea, vomiting and meningitis.

A **log-linear model** is a type of **regression analysis**. It is also conducted to determine the relative impact of independent variables upon a dependent variable, taking into account the fact that independent variables can act independently or in combination with each other. It assesses whether or not the result of their interaction together is different from the result of each of their actions alone.

Longitudinal analysis or *longitudinal research* is a kind of analysis or research that involves the observation of individuals or groups over time in order to assess change. *Longitudinal patterns* are those observed in investigations where repeated measurements or data are taken or recorded from the same subjects or groups over a period of time, or those observed from self-reported data recalled by subjects looking back on behaviors in their own lives.

A **multivariate analysis** examines the relationship between three or more variables in a statistical study.

n stands for **sample** size and denotes the number of people in a study.

p stands for *probability*. It is a measure or number that denotes the degree to which the results of a statistical study are real or may have been due to chance alone. If p=.05, it means the results have a 5 in 100 likelihood of being due to chance alone and a 95 out of 100 chance of being real. If p<.05, the results have a less than five in 100 likelihood of being due to chance and a better than 95 out of 100 chance of being real.

Pellagra is a vitamin deficiency syndrome; alcoholic pellagra occurs in alcoholics.

The ***phi* coefficient** is a statistical measure of association between two **variables**.

A **placebo** is any dummy medical treatment or medicinal preparation that has no specific pharmacological action. The term is most often used to describe a dummy medication administered to a control group in a controlled clinical trial, so that the effects of an experimental treatment can be assessed.

Psychopathology is a term used to describe the functional and structural manifestations of mental disorders and the branch of medicine that deals with the causes and nature of mental disease.

r stands for **correlation**, a statistical measure of association between two **variables** that indicates how likely they are to occur together.

R^2 (R-squared) is a value or number that denotes what percentage of the **variance** is explained in a statistical analysis called **regression analysis**.

Random sampling. See **sampling**.

Rational-emotive behavior therapy is a theory of personality and a system of psychological treatment developed in the 1950s by American clinical psychologist Albert Ellis. It emphasizes the roles that unrealistic expectations and irrational beliefs play in causing human misery.

Regression analysis is a statistical method for determining the relative impact of independent or explanatory **variables** acting simultaneously upon a dependent variable. The method enables a researcher to explain what percentage or degree of variability, or variance, in the dependent variable can be attributed to a given independent or explanatory variable. A **stepwise regression analysis** sets a minimum threshold or limit between those variables that are statistically significant and those that are statistically insignificant.

Rescaling is a method used in statistical analyses in order to change from one measurement scale to another. For example, results obtained from a survey sample of 11,000 can be rescaled so that they can be validly expressed for a population of 20,000,000.

Sampling denotes the means by which a person from a population to be studied is selected to answer survey questions or provide data in another way. In **random sampling**, all members of a population have an equal chance of being selected. In **non-random sampling**, some members of a population have a greater likelihood of being selected and others have a lesser likelihood of being selected. For example, a telephone survey conducted during nor-

mal daytime working hours will be less likely to include working persons than homemakers or retired persons as respondents. **Multistage sampling** is a kind of sampling of persons from a population that is carried out in a sequence of stages or steps. In a first stage, for example, a neighborhood within a given city might be selected. In a second stage, the city blocks within the neighborhood might be selected. Then the houses within the blocks will be selected, and finally, one person within each household will be selected.

Stepwise regression analysis. See **regression analysis**.

A ***t*-statistic** is a statistical value or number obtained as a result of applying a test of significance, a *t-test*, in order to determine the extent to which the results of a statistical study are real, rather than the results of chance alone. When used in **regression analysis**, it indicates the importance of a **variable** as an *explanatory variable*.

Tachyarrhythmia is rapid, irregular heartbeat.

Tau b is a statistical measure of association between two variables.

Toxoplasmosis is an acute or chronic widespread disease caused by the protozoon *Toxoplasma gondii*, which is found in the feces of cats. Most humans infected show no symptoms. When symptoms do occur, the disease may range from one that is mild and self-limiting, resembling mononucleosis, to one that is serious, causing extensive damage to the brain, eyes, skeletal and heart muscles, liver and lungs. Severe cases are usually seen in patients with weakened immune systems and in fetuses infected via the placenta.

A **variable** is an item of information obtained in a survey. For example, in a survey asking Canadians about their use of alcohol, the three items, age, sex, and the number of drinks taken per week, are each variables. A variable can take several values: age, for example, could range from 15 to 90 years; sex can be either male or female; the number of drinks per week could range from 0 to 35 or more. Variables can also be divided into "cause-type" and "consequence-type" variables. In a statistical study, the cause-type variables might be called *independent*, *explanatory*, or *predictor* variables; the consequence-type variables might be called *dependent* or *response* variables.

Variance is a measure of the variability of values that a **variable** can take. For example, in a sample of five people, the variable "age" could take the values of 19, 25, 28, 32 and 45. In another sample of five, all individuals could have the same age – 25. The first sample would have a larger variance than the second sample. Variance is measured by the *F*-statistic.

Weighting is a statistical method of correcting for any possible bias arising in a survey sample resulting from the **sampling** methods used to collect data. It takes into account and corrects for the effects of the unequal chances of persons in different subsections of a population being selected in a sample. It allows the data collected from the combination of persons in different subsections of a population at large to reflect the reality of the population at large by increasing or decreasing numerical values associated with the responses from each of the persons surveyed.

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Virginia Carver, PhD is a Program Consultant with the Ottawa (Ontario) Community Programs Office of the Addiction Research Foundation. She obtained her doctorate in psychology at the University of Ottawa. She has a particular interest in the issue of substance abuse among women and seniors and has been involved with community groups and agencies in the development of treatment services to address their needs. She co-edited a book, *Women, Work, and Wellness*, on the issue of women and workforce health, and is currently involved in a project to develop public information and caregiver training materials on the topic of seniors and substance use.

June Chaikelson, PhD

June Chaikelson, PhD is a Professor in the Department of Psychology at Concordia University (Montreal, Quebec) and an associate member of the Centre for Research in Human Development. She is a former Dean of Social Science at Concordia. She obtained her doctorate in psychology from McGill University. She is interested in the effects of lifestyles over the adult years on the functioning and well-being of the elderly. She and her colleagues have developed a new method for obtaining lifetime reports of substance (alcohol and tobacco) use.

Serge Chevalier, MSc

Serge Chevalier, MSc is Director of Public Health with the Montreal Centre Regional Board for Health and Social Services and works for the Department of Community Health at Hospital St. Luc in Montreal, Quebec.

Juanne Clarke, PhD

Juanne Clarke, PhD is a Medical Sociologist and Professor and past Chair of the Department of Sociology and Anthropology at Wilfrid Laurier University (Waterloo, Ontario) where she was the head of Women's Studies. She obtained her doctorate from the University of Waterloo, her master's from York University (Toronto, Ontario), and her baccalaureate from the University of Windsor (Ontario). She is cross-appointed with the Faculty of Social Work at Wilfrid Laurier and the Department of Sociology at the University of Waterloo. Her research interests lie in women's health issues and in feminist and other methodologies. She has received the Thérèse Casgrain fellowship for research on the politics of breast cancer. She has edited, written or co-written eight books and 30 research articles. She is a member of the Canadian Association of Psychosocial Oncology and numerous other academic organizations.

Christiane Dini, MA

Christiane Dini, MA received her master's degree in economics from McMaster University (Hamilton, Ontario). She has worked for the Addiction Research Foundation of Ontario as a Research and Development Associate in the former Prevention and Health Promotion Research and Development Department and in a similar position in the Clinical Research and Treatment Institute. She is currently a Senior Economic Policy Analyst at the Liquor Control Board of Ontario.

Marc Eliany, MA

Marc Eliany, MA co-ordinated Canadian Drug Strategy research programs in the Health Promotion Studies Unit in the Federal Department of Health and Welfare Canada in Ottawa (Ontario), including baseline studies such as *How Effective are Alcohol and Other Drugs Programs?* and national surveys such as the National Alcohol and Other Drugs Survey (NADS). In this capacity, he contributed to the development of drug surveys in Canada, giving much attention to populations at risk, such as youth, women and the elderly. He is currently on an assignment with the United Nations Drug Control Programmes in Vienna (Austria). Previously, he held positions with the National Parole Board and the Solicitor General of Canada. He has master's and baccalaureate degrees in Multidisciplinary Studies in Social Sciences and Administration from the Hebrew University in Jerusalem (Israel). He also holds a Human Engineering Management degree from the Technion Institute of Technology in Israel. Between 1976 and 1985, he studied Sociology at the doctoral level at Carleton University and economic analysis and international development at Ottawa University. Among his most significant contributions to drug research in Canada are a number of reports based on the NADS, including *Alcohol and Other Drugs Use by Canadians: Technical Report; How Effective are Alcohol and Other Drugs Prevention and Treatment Programs: A Review of Evaluation Studies; Alcohol and Other Drugs Use by Elderly Canadians; Alcohol and Other Drugs Use by Canadian Youth; The Smoking Behaviour of Canadians; The National Alcohol and Other Drugs Survey Highlight Report; Informal Education – A Structural Approach.* He was also editor of *Alcohol in Canada* and *Licit and Illicit Drugs in Canada.*

Lucia Farinon, MA

Lucia Farinon, MA has worked as a Research Associate at the Addiction Research Foundation in Toronto. She is currently pursuing further graduate studies.

Roberta Ferrence, PhD

Roberta Ferrence, PhD is Director of the Ontario Tobacco Research Unit and a Senior Scientist in the Social Evaluation and Research Department at the Addiction Research Foundation, in Toronto. She holds the rank of Associate Professor in the Department of Preventive Medicine and Biostatistics at the University of Toronto. Trained in Medical Sociology (MA) and Epidemiology (PhD), she has extensive experience in epidemiologic and survey research in the addictions field. She has served in an expert capacity on numerous task forces and committees. Much of her work has concerned tobacco use and tobacco control strategies, including policy and programming papers and reports. Of particular note is recent work dealing with: attitudes of the population of Ontario toward tobacco control policy; access of minors to tobacco; tobacco taxation policy; analyses of trends in long-term use, patterns of current tobacco use, and gender differences in tobacco use; the promotion of smoke-free families; nicotine dependence; and relationships among the use of alcohol, tobacco and other health-related behaviors. As a volunteer professional, she currently chairs the Task Force on Smoking for the Heart and Stroke Foundation of Ontario.

Kathryn Graham, PhD

Kathryn Graham, PhD has a doctorate in psychology and is a scientist at the Addiction Research Foundation in London, Ontario. Her recent work has been in the area of evaluation of addictions

treatment, with particular focus on older people, case management and relapse prevention. Other specialties include measurement and evaluation methods.

Lorraine Greaves, PhD

Lorraine Greaves, PhD is Director of the Centre for Research on Violence Against Women and Children and Professor of Sociology in the Human Services Division at Fanshawe College (London, Ontario). She is a long-time activist on women's issues, particularly in the areas of violence against women, and women and addictions. Currently, she serves on the Steering Committee of the International Network of Women Against Tobacco, and has also served in editorial capacities for the World Health Organization and the International Union Against Cancer. She is the author of the "Background Paper on Women and Tobacco," published by Health and Welfare Canada, and *Taking Control: An Action Handbook on Women and Tobacco*, published by the Canadian Council on Smoking and Health, as well as several chapters and articles on women's smoking and the women's movement in Canada.

Kathryn Harvey, MA

Kathryn Harvey, MA is a doctoral student in the History Department of McGill University (Montreal, Quebec) researching a dissertation on the social construction of class and gender among Montreal's Protestant elite during the latter half of the nineteenth century. This topic was inspired by her master's thesis research, completed at the University of Montreal, on wife battering among working-class families between 1869–79. She is also a member of the Montreal History Group, which is doing collective research funded by FCAR on women and public space in nineteenth-century Montreal.

Suzanne Hill, MA

Suzanne Hill, MA is a doctoral candidate in the Department of Sociology and Anthropology at Carleton University (Ottawa, Ontario).

Eva Janecek, BSc Phm

Eva Janecek, BSc Phm is Head of Pharmacy Services at the Addiction Research Foundation, in Toronto, and a Senior Tutor in the Faculty of Pharmacy at the University of Toronto, where she teaches fourth-year pharmacy students and pharmacy residents. She is a graduate of the University of Toronto and did one year of residency at the Addiction Research Foundation and postgraduate training in Drug Information at the Karolinska Institute in Stockholm, Sweden. Her current research interests are in the broad area of non-prescription and prescription medication abuse, with a focus on specific substances, including sedative-hypnotics, benzodiazepines and opiates. She has published in numerous pharmacy journals.

Florence Kellner, PhD

Florence Kellner, PhD is Associate Professor of the Department of Sociology and Anthropology at Carleton University (Ottawa, Ontario). She obtained her doctorate from Rutgers (New Jersey, USA), where she is on the Faculty of the Summer School of Alcohol Studies. Her research interests lie in the areas of social control and the phenomenology of addictions.

Gillian Leigh, PhD

Gillian Leigh, PhD is a Rehabilitation Psychologist at the Cape Breton Hospital in Sydney, Nova Scotia. She is a graduate in psychology from London University, England (BSc) and postgraduate of the University of Guelph (MA) and the University of Waterloo (PhD) in Ontario.

She has specialized in behavioral methods of research and evaluation, and has worked as a scientist in the development of research projects in sociobehavioral treatment for chronic alcohol abuse and in the identification and brief treatment of hazardous drinking in the community. She has also worked in residential care and in rehabilitation of persons with mental disabilities and chronic mental illness.

Lynn Lightfoot, PhD

Lynn Lightfoot, PhD received her Master of Applied Science and her doctorate in psychology at the University of Waterloo (Waterloo, Ontario). She is a psychologist in private practice with Psychological Consulting Services in London, Ontario. Previously, she served as Research Director of the Treatment Program Research Development Project at Queen's University in Kingston, Ontario for three years, then served as Centre Director and later as Eastern Ontario Regional Director with the Addiction Research Foundation for 10 years. Since 1983, she has been an Adjunct Assistant Professor of Psychology at Queen's University, where she is also the Principal Investigator on a National Health and Welfare Project, which is assessing the effects of computerized lifestyle assessment as a tool in the prevention and brief treatment of substance abuse problems. She is the author of over 50 scientific articles, book chapters, conference proceedings, and government reports in the field of substance abuse. She has specialized in the development and evaluation of substance abuse treatment programs for forensic populations since 1985. She has written and co-authored two treatment manuals and a staff training manual for Correctional Services Canada, and has conducted many training workshops and seminars. She has worked as a consultant to the Correctional Services of Canada and the U.S. National Institute of Mental Health, and was recently appointed to Ontario's Criminal Code Review Board.

Colleen Lundy, PhD

Colleen Lundy, PhD has worked in the addictions field as a practitioner, researcher and educator for 20 years. Her research and writing in this field have focused on the experiences of women and the development of services to meet their particular needs. She has also published in the area of violence in women's lives, both in personal relationships and in university and urban environments. She is currently a professor in the School of Social Work at Carleton University (Ottawa, Ontario). She obtained her doctorate in social work at Florida State University (Florida, USA), her master's at Carleton University and her baccalaureate (BScN) at the University of Ottawa.

Lisa J. MacGregor, MA

Lisa J. MacGregor, MA received her master's degree in economics from the University of Guelph (Guelph, Ontario), where she was a sessional lecturer in economic theory. She has worked as a Research and Development Associate in the former Prevention and Health Promotion Research and Development Department at the Addiction Research Foundation, and is currently a Senior Economic Policy Analyst at the Liquor Control Board of Ontario.

Shirley Mills, PhD

Shirley Mills, PhD is Associate Professor in the Department of Statistics and Mathematics at Carleton University (Ottawa, Ontario).

Pauline Morissette, PhD

Pauline Morissette, PhD is a social worker with a doctorate in community health from the Faculty of Medicine of the University of Montreal (Montreal, Quebec). She is currently Associate Professor in the School of Social Services at the University of Montreal and Associate Researcher in two research centres: the Centre for Health Promotion of Montreal and the Research Group on Psychoactive Substances in Quebec (RISQ). Her research focuses on risky behaviors among women. She has undertaken a number of projects on the use of alcohol and psychotropic drugs among working women and on sexual behaviors that are high risk or self-protecting among women seeking a partner. She has written a number of articles on these topics and has collaborated on a number of publications on women's health and its psychosocial issues. Results have been presented in a number of national and international symposiums. For the past several years, she has been involved in the development and management of employee assistance programs in work environments where female workers predominate, with particular attention to the educational system.

Louise Nadeau, PhD

Louise Nadeau, PhD is an Associate Professor in the Department of Psychology at the University of Montreal (Quebec). She was the co-ordinator of the Substance Abuse Certificate at the Faculty of Continuing Education at the University of Montreal, a program she created and directed. After receiving a master's in psychology at the University of Montreal, she worked at Portage, a therapeutic community for drug addiction where she was Director of Treatment for two years. It was in this setting that she developed her interest in addiction and women's mental health. She decided to interrupt her career to pursue doctoral studies. Her thesis was on the subject of the social origins of alcoholism in women. This work was done at the Université de Québec in Montreal and at Bedford College in London. Her more recent work is in the field of alcohol epidemiology and on clinical research. This research is linked with the *Recherche et intervention sur les substances psychoactives/ Québec* (RISQ), a team founded by the *Conseil québécois de la recherche sociale* and affiliated with the treatment centre, Centre d'accueil Domrémy-Montréal. She received the Professional Award of the Corporation of Psychologists of the Province of Quebec, and she was appointed Chair of the Permanent Committee on Drugs of the Government of Quebec. She has co-chaired the section Focus on Women of the International Council of Alcoholism and Addictions. She has also chaired the board of the Centre d'accueil Domrémy-Montréal. Her publications include: *Va te faire soigner, t'es malade*, a book on women's mental health; a monograph on women and alcohol, *Les Femmes et l'alcool en Amérique du Nord et au Québec*; and *Vivre avec l'alcool : la consommation, les effets, les abus*. She teaches at the University of Montreal and in other universities and frequently addresses the media.

Antoinine Paquin, MD

Antoinine Paquin, MD was a physician in the Department of Community Health at St. Luc Hospital in Montreal, Quebec. She has recently retired.

Linda L. Pedersen, PhD

Linda L. Pedersen, PhD is a Professor in the Department of Epidemiology and Biostatistics at the University of Western Ontario (London, Ontario). She has conducted numerous studies on factors related to the initiation and cessation of smok-

ing and on public policy initiatives related to restrictions on smoking. She has published over 50 articles on these topics.

Kim Scott, MSc

Kim Scott, MSc received her master's in health studies from the University of Waterloo (Waterloo, Ontario) and her baccalaureate from Carleton University (Ottawa, Ontario). She is an evaluator and writer in Maniwaki, Quebec, and a sessional lecturer at Carleton University with the Pauline Jewitt Institute for Women's Studies. She is an Algonquin woman, raised in an extended family, who has worked at the community level with adolescents, developing community health and social services, advocating children's rights, and publishing articles on addictions in the Canadian indigenous community, on the ethics of research in indigenous communities, and on the relationship between self-esteem and substance use in Native Canadian adolescents. Her research interests lie in the relationships between self-esteem or self-efficacy and health.

Gina Stoduto, MEd

Gina Stoduto received her Master of Education in Applied Psychology from the Ontario Institute for Studies in Education, University of Toronto. She has been with the Addiction Research Foundation for nine years as a Research Associate in the Social Evaluation and Research Department. Her main work interests have been in the area of alcohol and drugs in traffic safety, the criminal justice system, and among youth.

Ellen Tabisz, MSW

Ellen Tabisz, MSW is Executive Director of the Women's Post-Treatment Centre and Research Coordinator of the Riverview Health Centre in Winnipeg, Manitoba. She received her master's degree from the University of Manitoba. She has been Coordinator of the Department of Social Work and Head of the Clinical Research Centre at St. Boniface General Hospital in Winnipeg. She is also an adjunct professor in the Faculty of Social Work, University of Manitoba. In 1987, she established the Elders' Health Program, a chemical dependency intervention and treatment program for the elderly. She has received grants from National Health Research and Development Program to study the psychosocial impact of dialysis on patients. She has published papers in the *Canadian Journal on Aging, Clinical Gerontologist* and the *Journal of Gerontological Nursing*.

Joy Thompson, PhD

Joy Thompson, PhD worked for the Alberta Alcohol and Drug Addiction Commission (AADAC) in Edmonton, Alberta. She now lives in Australia.

Wilfreda E. Thurston, PhD

Wilfreda E. Thurston, PhD is Assistant Professor in the Department of Community Health Sciences at the University of Calgary (Calgary, Alberta). Her doctorate is from the University of Calgary and she also has degrees from Acadia University (BA) and Memorial University of Newfoundland (MSc). She was one of the founders and a Director of Transition House, a shelter for battered women in St. John's, Newfoundland. Previously, she worked in prevention in provincial addictions agencies in New Brunswick and Newfoundland, with a special focus on women and addictions. Her research interests include the health and safety of underserved populations in the workforce and the community at large – notably, women and ethnic or

racial groups; promotion of healthy weights among women; alcohol use and social factors; prevention of violence against women and children; and health promotion program development and evaluation. Her publications include: *With Two Pennies in My Pocket, I Just Feel Not So Helpless: A Report on the Mental and Occupational Health Promotion Needs of Immigrants in Calgary* (with Anne McGrath) and *Preventing Child Sexual Abuse: Reviews and Research* (with Chris Bagley).

Ikuko Webster, PhD

Ikuko Webster, PhD obtained her doctorate at Carleton University (Ottawa, Ontario), where she works in the Statistical Consulting Centre.

Women make up the majority of Canada's population, but their health concerns have traditionally been studied only as an extension of men's. *Women's Use of Alcohol, Tobacco and Other Drugs in Canada* is the first comprehensive study of women and substance abuse in Canada.

In this groundbreaking collection of essays, specialists from a wide variety of disciplines bring a feminist perspective to bear on the specific substance abuse issues that affect women. Topics covered include: the history of women's substance use, substance use throughout the life cycle, multicultural issues, gender differences, prevention and treatment, and policy issues.

Les femmes comptent pour la majorité de la population canadienne. Cependant, les préoccupations en matière de santé des femmes sont traditionnellement étudiées simplement à titre secondaire, comme prolongement de la santé des hommes. *Les Canadiennes et l'usage d'alcool, de tabac et d'autres drogues* est la première étude détaillée qui s'intéresse aux Canadiennes et leur usage abusif d'alcool et d'autres drogues.

Cet ouvrage innovateur réunit les comptes rendus de spécialistes de domaines variés qui ont abordé des questions précises de toxicomanie touchant les femmes d'un angle féministe. Les sujets abordés sont notamment : l'histoire de la toxicomanie chez les femmes, la toxicomanie à travers les étapes de la vie, les questions multiculturelles, les différences de consommation selon le sexe, la prévention et le traitement et certaines questions politiques.

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